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ABSTRACT

This book provides information necessary to establish and implement a third party reimbursement system for special education and related services within the public school setting. The first chapter traces the legal and historical precedent from the enactment of Public Law 94-142 through the interpretation of P.L. 100-360. The second chapter details the major issues surrounding third party reimbursement systems including child and family related issues and implementation and funding issues. The third chapter describes the current activities of the state departments of education and Medicaid systems with states listed alphabetically and individual contact information provided. Provided in the fourth chapter are federal credential requirements, third party coverage sources, available system options, samples of surveys for determining resources, and lists of additional resources by state. The fifth chapter covers billing and reimbursement terminology, common procedure and diagnostic codes by discipline, and how to determine usual and customary charges. The sixth chapter reviews Medicaid, the Early Periodic Screening Diagnosis and Treatment program, and other federally funded third party reimbursement sources. The seventh chapter provides the definitions of major insurance carriers and health maintenance organizations as well as a listing of major insurers in the United States. The eighth chapter reviews documentation parameters while the ninth discusses implementation strategies regarding data collection, design and use of forms, training, evaluation of results, and ways to effect change. A bibliography lists 23 publications. (DB)

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Third Party Payment for Funding Special Education and Related Services

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This text was developed to provide the basic information necessary to establish and implement a third party reimbursement system within the public school setting. The information and strategies regarding the issues and billing practices reflect the experience and research of the author. Although the resources and listings provided have been carefully researched and checked for accuracy, it must be recognized that this is a new and evolving area. Therefore, neither the author nor the publisher accepts any responsibility or liability for errors, omissions, misuse or misinterpretations of the resources and listings contained herein.

This publication was designed to provide accurate and authoritative information in regard to the subject matter covered. It is published with the understanding that neither the author nor the publisher is engaged in rendering legal, accounting or other professional service. If legal advice or other expert assistance is required, the service of a competent professional should be sought.

Third Party Payment for Funding Special Education and Related Services

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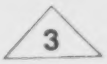

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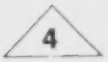

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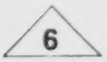

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Historical Background

Public Law (P.L.) 94-142, the Education for All Handicapped Children Act,[1] was signed into law in 1975. This law required that a free and appropriate public education be made available to all children with handicaps at no cost to their parents. The rights identified in P.L. 94-142 are a condition for the receipt by states of federal formula grants under Part B of the Education of the Handicapped Act.[2] These rights were also established under the broader civil rights mandate in the Rehabilitation Act of 1973, Section 504.[3] Federal assistance cannot be granted to state education agencies without compliance with the civil rights mandate.

The regulations and interpretations issued for implementation of P.L. 94-142 require that each child with a handicap be offered, at no cost to the child or the child's parents, a free and appropriate public education, including those special education and related services needed by the child. The special education and related services a child receives must be identified on the basis of a comprehensive evaluation and described in an individual education plan (IEP), which must be developed jointly by school staff and parents.

P.L. 94-142 defines "related services" as

> transportation, and such developmental, corrective and other supportive services (including speech-language pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as are required to assist a handicapped child to benefit from special education, and includes early identification and assessment of handicapping conditions in children. The term also includes school health services, school social work services, and parent counseling and training.[4]

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[1] P.L. 94-142, 20 U.S.C. 1400-1485; 34 C.F.R. Part 300.

[2] 20 U.S.C. 1411-1420; 34 C.F.R. Part 300.

[3] 29 U.S.C. 706(8); 34 C.F.R. Part 104.

[4] 34 C.F.R. Part 300.13(a).

When Congress enacted P.L. 94-142, it was not their intention that education agencies would become the sole fiscal source for all related services provided as part of a child's individual education plan. The United States Senate Committee on Labor and Public Welfare stated that a school district's obligation to provide special education and related services at no cost to the parents of a child or youth with a handicapping condition

> is not to be construed to prohibit charges by the educational agency to insurers, public programs, and others for hospital care, health services, rehabilitation, and other non-educational services. States are encouraged to utilize all sources of support for comprehensive services for handicapped students.[5]

In 1977, the regulations which interpret P.L. 94-142 were published in the Code of Federal Regulations.[6] These regulations indicated that

> Each state may use whatever state, local, Federal, and private sources of support which are available in the state to meet the requirements of this part. For example, when it is necessary to place a handicapped child in a residential facility, a State could use joint agreements between the agencies involved for sharing the cost of placement.
>
> Nothing in this part relieves an insurer or similar third party from an otherwise valid obligation to provide or to pay for services provided to a handicapped child.

The passage of P.L. 94-142 indicates that the intent of Congress was that all sources of funds, including federal, state, local and private, should be utilized to meet the needs of children with handicaps. It is also clearly stated that third party payors were not exempt from their obligation to pay for special education services because P.L. 94-142 was enacted.

Following the passage of this landmark federal legislation, special education programs and budgets expanded dramatically. When P.L. 94-142 was enacted in 1975, the federal share of financing the cost of special education and related services was set at 40 percent of the *average* per pupil expenditure as established nationwide. Ever since P.L. 94-142 took effect, however, the federal financial contribution has been less than 10 percent of the excess cost.

A study conducted by Rand Corporation in 1981 reported that the federal contribution was less than 7 percent out of an average total expenditure for special education and related services of $3,500 per child. The average per pupil expenditure varies by state and local school district. The study indicated that the average state contribution covered 26 percent, with the remaining 67 percent provided by local funds. The study further indicated that, on the average, more than 50 percent of per child expenditures were allocated to related service costs. In almost all cases detailed, the federal, state, and local funds identified were totally from education sources.

As special education programs and the legal responsibilities of state and local education agencies have expanded, the willingness of other public agencies and private sources to provide both the services and the payment for related services has dramatically declined. A

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5 Senate Report No. 94-168, 94th Congress, 1st Session 32 (1975).

6 34 C.F.R. Part 300.301(a)(b).

recent report sponsored by the Congressional Commission and one by the General Accounting Office (GAO) have concluded that some state and local health and welfare agencies have maintained the position that education agencies must support the costs for "related services," despite the availability of federal funding. This position prevails in some states despite the fact that funding of "related services" through education funding is more expensive for a state than funding the same costs through the Medicaid program. Currently the state and local contribution for special education funding is approximately 95 percent. The federal contribution to states in Medicaid dollars ranges from 50 percent to 80 percent.

The use of private insurance proceeds to cover the cost of special education and related services was interpreted by the Office of Special Education in 1980. The policy interpretation was prompted by an education agency's request for clarification regarding the authority to require parents to file insurance claims and the agency's "right to" use those proceeds to pay for special education services. The interpretation indicated that the proceeds from private insurance could be used to pay for special education and related services, but that the use of these funds must be voluntary on the part of the insured and any and all costs that may be incurred as a result of the claim must be paid by the state or local education agency.

During the early 1980s Congress became concerned that state and local education agencies were assuming the total cost of providing special education and related services. Congress was specifically concerned that other federal funding programs, such as Medicaid, were not paying for covered services because the services were identified in the child's individual education plan (IEP). Congress requested that the GAO conduct a study on the financing of health and educational services for children with handicaps. In their request, Congress indicated that "It was not Congress' intent in passing P.L. 94-142 that financial responsibilities previously assumed by health, welfare and other human services agencies be transferred to state and local education agencies."[7]

The recommendations in the GAO report to Congress prompted changes in legislative language related to Part B (P.L. 94-142) through the passage of P.L. 99-457 in 1986.[8] The legislative changes clarified financial responsibility for required services and required states to develop interagency agreements to determine the financing of special education and related services to children with handicaps. The Education of the Handicapped Act (P.L. 99-457) contains provisions that were designed to lessen the financial burdens for special education and related services currently borne by state and local education agencies. The new provisions directed states not to reduce or deny assistance available to children with handicaps under the Maternal and Child Health program (Title V of the Social Security Act)[9] and under the Medicaid program (Title XIX of the Social Security Act)[10] because of the child's right to services under P.L. 94-142.

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[7] General Accounting Office, "Financing Health and Educational Services for Handicapped Children," HRD-86-62 BR, July 1986.

[8] P.L. 99-457, 100 Stat. 1145-1177, 1986 *U.S.Code Cong. and Admin. News: Vol. 1.*

[9] 42 U.S.C. 701.

[10] 42 U.S.C. 1396.

The following outlines the EHA, Part B, as amended by P.L. 99-457, and its interpretation in relation to the financing of special education and related services. The author thanks Stan Dublinske, Ed.D., Director, Professional Practices Department, American Speech-Language-Hearing Association, for providing the language and report comparisons.

Statute Language

Section 612 Eligibility Requirements

(6) The State Education agency shall be responsible for assuring that the requirements of this subpart are carried out and that all educational programs for handicapped children within the State, including all such programs administered by any other State or local agency, will be under the general supervision of the persons responsible for educational programs for handicapped children in the state educational agency and shall meet education standards of the State educational agency.

This paragraph shall not be construed to limit the responsibility of agencies other than educational agencies in a State from providing or paying for some of the costs of a free appropriate public education to be provided handicapped children in the State.

Report Language

Supplement, Not Supplant; Interagency Coordination

This section of the bill clarifies the relationship among public agencies for providing or paying for services set out in a child's individualized education program. This issue was then the subject of a recent report entitled "[S]pecial Education — Financing Health and Educational Services [for] Handicapped Children," prepared by the United State[s] General Accounting Office (GAO/HRD-086-62BR July 1986).

The GAO Report concludes that Congress, in enacting P.L. 94-142, established a single line of authority and placed this authority with educational agencies. This means that if there are disputes among agencies regarding responsibility for paying for a particular service, then pending the resolution, the educational agency must ensure that the handicapped child receives the services set out in his or her IEP. The effect of this policy is to prevent buckpassing among agencies from occurring.

Although P.L. 94-142 designated the State education agency as responsible for ensuring that handicapped children receive a free appropriate public education, GAO found that it did not make the educational agency solely financially responsible for all services provided. Thus with respect to which agency must ultimately pay for the appropriate services, Congress intended that the services be paid for from various sources, including funds appropriated under P.L. 94-142, State and local educational funds, as well as funds from other Federal, State and local sources such as Medicaid for which the handicapped children qualify.

In support of this conclusion, GAO (p. 29) quotes the Senate Report accompanying P.L. 94-142:

". . . the state educational agency is responsible for assuring that funds for the education of handicapped children under other Federal laws will be utilized . . .[.]"

". . . there are local and state funds and other Federal funds available to assist in this process. Any funds available from the Federal Government are clearly in addition to funds provided under this Act and are available to states to assist them in carrying out their responsibilities under state laws, state constitutions, and the U.S. Constitution, and should be so utilized."

In sum, Congress established a legal framework under which one agency is ultimately accountable (the educational agency) and multiple agencies are expected to pay for appropriate services (educational agencies as well as health, welfare, and other social service agencies).

The Committee bill include[s] four amendments to Part B that reaffirm and operationalize congressional intent in this regard. The amendments: (1) will re-establish an important part of the Federal, State, and local base on which EHA was to have been buil[t]; (2) avoid the tendency to distort the IEP process because of Medicaid funding consideration[s]; (3) provide an efficient system for supporting the provision of special education and related services to handicapped children; and (4) provide a Federal model for interagency coordination.

Section 612(6) of the Act is amended by clarifying the policy set forth therein placing ultimate responsibility on the State educational agency for ensuring compliance with the requirements of Part B of the Act. The bill explains that this policy should not be construed to limit the responsibility of agencies other than educational agencies in a State from providing or paying for some of [*sic*] all of the costs of free appropriate public education to be provided handicapped children in the state.

Statute Language

Section 613 State Plans

(a) (9) provide satisfactory assurance that Federal funds made available under this Part (A) will not be commingled with State funds, and (B) will be so used as to supplement and increase the level of Federal, State, and local funds (including funds that are not under direct control of State or local educational agencies) expended for special educational and related services provided to handicapped children under this part and in no case to supplant such Federal, State and local funds, except that, where the State provides clear and convincing evidence that all handicapped children have available to them a free appropriate public education, the Secretary may waive in part the requirement of this clause if he concurs with the evidence provided by the State;

Report Language

This section of the bill also amends the State plan provision in Part B in three ways. First, the "supplement not supplant" assurance (section 613(a)(9)(B)[)] is amended. As amended, the provision states that the State must provide satisfactory assurance that Federal funds made available under Part B will be used to supplement and increase the level of Federal, State and local funds (including funds that are not under direct control of State o[r] local educational agencies) expended for special education and related services provided to handicapped children under Part B and in no case to supplant such Federal, State and local funds. The amendment retains the waiver provision in current law. The assurance is submitted by the State, through the State educational agency.

It is the Committee's intent that under the "supplement, not supplant" provision, as amended, fund[s] provided under Part B will not be used to satisfy financial commitment for services which would have been paid for by other Federal, State and local agencies (including health agencies) pursuant to policy or practice but for the enactment of Part B and the listing of the service in a handicapped child's individualized educational program. The intent of this provision is to ensure that services currently being provided or paid for by other agencies for handicapped children will be continued.

Statute Language

Section 613(a)(13) New Paragraph

(13) set forth policies and procedures developing and implementing interagency agreements between the State educational agency and other appropriate State and local agencies to (A) define the financial responsibility of each agency for providing handicapped children and youth with free appropriate public education, and (B) resolve interagency disputes, including procedures under which local educational agencies

Report Language

Second, section 613(a) of the Act is amended by adding a requirement that the State set forth policies and procedures for developing and implementing interagency agreements between the State educational agency and other appropriate State and local agencies to define the financial responsibility of each agency for providing handicapped children with a free appropriate public education and resolve interagency dis-

may initiate proceedings under the agreement in order to secure reimbursement from other agencies or otherwise implement the provisions of the agreement.

putes, including procedures under which local educational [a]gen[c]ies may initiate proceedings under the agreement in order to secure reimbursement from other agencies or otherwise implement the provisions of the agreement.

It is the committee's intent that in the formulation of an interagency agreement the State educational agency obtain meaningful input from local educational agencies or their representatives.

Statute Language

Section 613(e) New Subsection

(e) This Act shall not be construed to permit a State to reduce medi[c]al and other assistance available or alter eligibility under titles V or XIX of the Social Security Act with respect to the provision of a free appropriate public education for handicapped children with[in] the State;

Report Language

Third, section 613 of the Act is amended by adding a new subsection (e) which provides that Part B shall not be construed to permit a State to reduce medical or other assistance available or to alter eligibility under Title V or Title XIX of the Social Security Act with respect to the provision of a free appropriate public education for handicapped children within the State.

The amendment is not intended in any way to suggest that medical assistance provided under Medicaid pays for traditional educational services; rather, this provision states that the requirements in Part B should not be construed to permit the elimination from Medicaid coverage of those health[-]related or other services covered by Title V or Title XIX of the Social Security Act which would have been provided but for the fact that they are required to be provided by a child's IEP.

Congress went beyond the additions and changes in Part B of the amendments included in P.L. 99-457 when it added Part H, "Handicapped Infants and Toddlers Early Intervention Program," to the Education of the Handicapped Act in 1986.[11] P.L. 94-142 and 99-457, Part B, strongly encourage states to provide services to handicapped children ages 3 through 21 and *require* services for children who are school age through 21 years. In fact, the law imposes sanctions for those states not providing services to children age 3 to 21 by the 1991-92 school year.

P.L. 99-457, Part H, encourages states to provide services to infants and toddlers with handicaps age birth through 2 years. Part H uses the term "early intervention services" to describe the services available to infants and toddlers with handicapping conditions,

[11] 20 U.S.C. 1471-1485; 34 C.F.R. Part 300.13-300.16.

whereas P.L. 99-142 and P.L. 99-457, Part B, use the terms "special education and related services." (Related services are defined on page 5 of this chapter.)

The early intervention services for children 3-5 years old listed in Part H are broader than those contained in the definition of related services but have the same range of therapeutic intervention services. Early intervention services may include audiology, case management services, early identification, screening and assessment services, family training, counseling and home visits, health services, medical services only for diagnostic and evaluation purposes, occupational therapy, physical therapy, psychological services, special instruction and speech-language pathology.

The definitions and regulations outlined in Parts B and H differ; they encourage and mandate services differently by age group. The laws regulating services to preschool children with handicaps are less clear than those affecting school-aged children. The states of Iowa, Nebraska, Minnesota, South Dakota, Maryland and Michigan mandate the regulations outlined in Part B to children with handicaps ages birth through 21. All other states are regulated by both laws. Each state has a designated "lead agency," which is responsible under Part H for establishing a state plan to meet the needs of children with handicaps.

EHA, Part H, requires that each state's designated lead agency provide early intervention services for handicapped infants and toddlers at no cost, except where federal and state law provides for a system of payments by families including the use of a sliding fee schedule. Congress's enactment of P.L. 99-457 established that it is the policy of the United States to provide financial assistance to states to "facilitate the coordination of payment for early intervention services from Federal, state, local and private sources (including public and private insurance coverage)."[12]

In 1989 the regulations interpreting Part H of the Education of the Handicapped Act as related to financial matters, fees, and payor of last resort were published. They included the following:[13]

POLICIES AND PROCEDURES RELATED TO FINANCIAL MATTERS

303.520 Policies related to payment for services.

(a) *General.* Each lead agency is responsible for establishing State policies related to how services to children eligible under this part and their families will be paid for under the State's early intervention program. The policies must—

(1) Meet the requirements in paragraph (b) of this section; and

(2) Be reflected in the interagency agreements required in 303.523.

(b) *Specific funding policies.* A State's policies must—

(1) Specify which functions and services will be provided at no cost to all parents;

12 20 U.S.C. 1471(b)(2); 34 C.F.R. Part 303.1(b).

13 See cite at the end of each section.

(2) Specify which functions or services, if any, will be subject to a system of payments, and include—

(i) Information about the payment system and schedule of sliding fees that will be used; and

(ii) The basis and amount of payments; and

(3) Include an assurance that—

(i) Fees will not be charged for the services that a child is otherwise entitled to receive at no cost to parents; and

(ii) The inability of the parents of an eligible child to pay for service will not result in the denial of services to the child or the child's family.

(c) *Procedures to ensure the timely provision of services.* No later than the beginning of the fifth year of a State's participation under this part, the State shall implement a mechanism to ensure that no services that a child is entitled to receive are delayed or denied because of disputes between agencies regarding financial or other responsibilities. (Authority: 20 U.S.C. 1476(b)(9))

303.521 Fees.

(a) *General.* A State may establish, consistent with 303.12(a)(3)(iv), a system of payments for early intervention services, including a schedule of sliding fees.

(b) *Functions not subject to fees.* The following are required functions that must be carried out at public expense by a State, and for which no fees may be charged to parents:

(1) Implementing the child find requirements in 303.321;

(2) Evaluation and assessment, as included in 303.322, and including the functions related to evaluation and assessment in 303.12.

(3) Case management, as included in 303.5 and 303.344(g).

(4) Administrative and coordinative activities related to—

(i) the development, review, and evaluation of IFSP's in 303.340 through 303.346; and

(ii) Implementation of the procedural safeguards in Subpart E, and the other components of the statewide system of early intervention services in Subparts D and F.

(c) *States with mandates to service children from birth.* If a State has in effect a State law requiring the provision of a free appropriate public education to children with handicaps from birth, the State may not charge parents for any services (e.g., physical or occupational therapy) required under that law that are provided to children eligible under this part and their families. (Authority: 20 U.S.C. 1472(2))

303.522 Identification and coordination of resources.

(a) Each lead agency is responsible for—

(1) The identification and coordination of all available resources for early intervention services within the State, including those from Federal, State, local, and private sources; and

(2) Updating the information on the funding source in paragraph (a)(1) of this section, if a legislative or policy change is made under any of those sources.

(b) the Federal funding source in paragraph (a)(1) of this section include[s]—

(1) Title V of the Social Security Act (relating to Maternal and Child Health);

(2) Title XIX of the Social Security Act (relating to the general Medicaid Program, and EPSDT);

(3) The Head Start Act;

(4) Parts B and H of the EHA;

(5) Subpart 2 of the Part D of Chapter 1 of the Title I of the Elementary and Secondary Education Act of 1965, as amended;

(6) The Developmentally Disabled Assistance and Bill of Rights Act (Pub. L. 94-103); and

(7) Other Federal programs. (Authority: 20 U.S.C. 1476(b)(9)(B))

303.523 Interagency agreements.

(a) *General.* Each lead agency is responsible for entering into formal interagency agreements with other State-level agencies involved in [the] State's early intervention program. Each agreement must meet the requirements in paragraphs (b) through (d) of this section.

(b) *Financial Responsibility.* Each agreement must define the financial responsibility of the agency for paying for early intervention services (consistent with State law and the requirements of this part).

(c) *Procedures for resolving disputes.* (1) Each agreement must include procedures for achieving a timely resolution of intra- and interagency disputes about payments for a given service, or disputes about other matters related to the State's early intervention program. Those procedures must include a mechanism for making a final determination that is binding upon the agencies involved.

(2) The agreement with each agency must—

(i) Permit the agency to resolve its own internal disputes (based on the agency's procedures that are included in the agreement), so long as the agency acts in a timely manner; and

(ii) Include the process that the lead agency will follow in achieving resolution of intra-gency disputes. If a given agency is unable to resolve its own internal disputes in a timely manner.

(d) *Additional components.* Each agreement must include any additional components necessary to ensure effective cooperation and coordination among all agencies involved in the State's early intervention program. (20 U.S.C. 1476(b)(9)(F))

303.527 Payor of last resort.

(a) *Nonsubstitution of funds.* Except as provided in paragraph (b)(1) of this section, funds under this part may not be used to satisfy a financial commitment for services that would otherwise have been paid for from another public or private source but for the enactment of Part H of the Act. Therefor[e], funds under this part may be used only for early intervention services that an eligible child needs but is not currently entitled to under any other Federal, State, local or private source.

(b) *Interim payments; reimbursement.*

(1) If necessary to prevent a delay in the timely provision of services to an eligible child or the child's family, funds under this part may be used to pay the provider of services, pending reimbursement from the agency or entity that has ultimate responsibility for the payment.

(2) Payments under paragraph (b)(1) of this section may be made for—

(i) Early intervention services, as described in 303.12;

(ii) Eligible health services (see 303.13); and

(iii) Other functions and services authorized under this part, including child find, and evaluation and assessment.

(3) The provisions of paragraph (b)(1) of this section do not apply to medical services or "well-baby" health care (see 303.13(c)(1)).

(c) *Non-reduction of benefits.* Nothing in this part may be construed to permit a State to reduce medical or [o]ther[ ] assistance available or to alter eligibility under Title V of the Social Security Act (SSA) (relating to maternal and child health) or Title XIX of the SSA (relating to Medicaid for children eligible under this part) within the State. (Authority: 20 U.S.C. 1481)

Note: The Congress intended that the enactment of Part H not be construed as a license to any agency (including the lead agency and other agencies in the State) to withdraw funding for services that currently are or would be made available to eligible children but for the existence of the program under this part. Thus, the Congress intended that other funding source[s] would continue, and that there would be greater coordination among agencies regarding the payment of costs.

The Congress further clarified its intent concerning payments under Medicaid by including in section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) an amendment to Title XIX of the Social Security Act. That amendment states, in effect, that nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary of Health and Human Services to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a handicapped infant or toddler because such services are included in the child's IFSP adopted pursuant to Part H of the EHA.

On June 29, 1988, the case of *Bowen v. Massachusetts,*[14] heard by the Supreme Court, upheld the 1985 ruling of the U.S. Court of Appeals for the First Circuit Court that the State of Massachusetts was to use Medicaid funds for rehabilitation services provided to mentally retarded patients residing in an intermediate care facility when those services were provided by mental health and educational personnel. The ruling clearly established the position that services provided as part of a child's IEP cannot be denied reimbursement merely because they are in an IEP. The State of Massachusetts originally denied payment to the intermediate care facility on the premise that federal Medicaid funds could not be used to pay for services provided as part of a child's IEP. The court held that denial of payment by the State of Massachusetts directly violated federal Medicaid legislation allowing reimbursement for

[14] 108 S. Ct. 2722 (1988); EHLR 559:422.

"health or rehabilitative services." The ruling further indicated that determination of a service as educational or health related should be based on the nature of the service and not the state's method of providing or administering the service.

In July 1988, three days after the Supreme Court's decision in *Bowen v. Massachusetts*, the Medicare Catastrophic Coverage Act was signed into law.[15] The Act amended Title XIX to prohibit the Secretary of Health and Human Services from restricting Medicaid funds from reimbursement for services provided to a child with a handicap because services were also outlined in the child's individual education plan (IEP). The amendment indicates that

> Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary [of HHS] to prohibit or restrict payment under subsection (a) for medical assistance for covered services furnished to a handicapped child because such services are included in the child's Individual Education Program established pursuant to Part B of the Education of the Handicapped Act or furnished to a handicapped infant or toddler because such services are included in the child's Individualized Family Service Plan adopted pursuant to Part H of such Act.[16]

Conference Committee Report Number 357 clarified congressional intent as follows:

> The conference agreement clarifies that Federal Medicaid matching funds are available for the cost of health services, covered under a State's Medicaid plan, that are furnished to a handicapped child or a handicapped infant or toddler, even though such services are included in the child's IEP or IFSP. Under the Education for All Handicapped Children Act of 1975, P.L. 94-142, children with handicaps are entitled to a free appropriate public education in conformity with an IEP which describes the educational and "related services" necessary to meet the child's unique needs. While the state education agencies are financially responsible for educational services, in the case of a Medicaid-eligible handicapped child, state Medicaid agencies remain responsible for the "related services" identified in the child's IEP if they are covered under the state's Medicaid plan, such as speech [language] pathology and audiology, psychological services, physical and occupational and therapy and medical counseling and services for diagnostic and evaluation purposes.[17]

HCFA has indicated that the amendment was intended "to ensure that services that would ordinarily be provided or paid for by other agencies for handicapped children would be continued."[18]

In addition to education legislation, Congress significantly expanded the scope of the Early Periodic, Screening, Diagnostic and Testing (EPSDT) program for Medicaid eligible children and raised the financial eligibility level (for qualifying for Medicaid) to 133 percent

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15 P.L. 100-360, 102 Stat. 683.

16 34 C.F.R. 303.527 (*See* 20 U.S.C. 1481).

17 Conference Report No. 100-661, Conference Agreement on HR 2470, Medicare Catastrophic Coverage Act, 268-269.

18 55 *Federal Register*, February 21, 1990, 6015-6018.

of the federally established poverty level—in the 1989 Omnibus Budget Reconciliation Act (OBRA).[19] The combination of the expansion of services and providers within the EPSDT program and the ability to qualify a greater number of children for Medicaid—because of the increase in financial qualifications to 133 percent of poverty—was significant. EPSDT is currently a very underutilized program. The OBRA changes provide school districts with the ability to access the EPSDT program for reimbursement of IEP-related services. These changes may make the EPSDT program one of the best ways to meet the health care needs of this nation's children. Chapter 6 of this publication provides details regarding EPSDT program specifics.

The legislation, court rulings and numerous policy interpretations of P.L. 94-142 and P.L. 99-457 recognize that while education agencies are fiscally responsible for *educational* services, they are not the only agency fiscally responsible for *related* services. Since 1975 Congress, the courts and the U.S. Department of Education have clearly stated that state and local education agencies should use any source of funds available to pay for the special education and related services outlined in a child's IEP. The impetus for school districts to access third party reimbursement is based upon the recognition of shared fiscal responsibility for the related services provided to children and youth with handicapping conditions. There currently are state and local education agencies accessing third party reimbursement in direct response to the federal and state laws that mandate these agencies to seek additional money beyond the Part B and Part H funding for special education related services and early intervention services.

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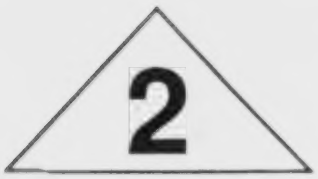
[19] P.L. 101-239, 42 U.S.C. 1396(a).



Issues

Many issues surround the implementation of a third party reimbursement system within the realm of education. This chapter highlights these major issues and provides strategies and resources for moving beyond them. Each district will face its own set of issues and concerns.

Districts will need to establish policies and outline procedures to face the issues as they relate to the goals and objectives they have established for implementing a third party reimbursement system.

The strategies outlined below represent the experience and opinion of the author. The issues are divided into two areas: Child and Family Related Issues and Implementation and Funding Issues.

CHILD AND FAMILY RELATED ISSUES

A. Can a School District Legally Access Third Party Reimbursement When Students Are Entitled to a "Free Appropriate Public Education?"

The federal law requires that services be provided at no cost to students, their parents and families. However, the law also clearly provides the authority for school districts to use every available funding source to pay for services even though the law and the U.S. Department of Education policies are specific in that parents and families cannot be required to incur a financial loss. The following types of financial loss are forbidden.

a. The payment of any copayment or deductibles by the family cannot be required.

b. The use of insurance dollars cannot decrease or use up lifetime insurance benefits.

c. The use of third party reimbursement cannot increase premiums to the family or cause a cancellation of the family's policy.

There are insurance policies that include lifetime maximums or "caps" per individual or family insured. The estimate of the number of policies that contain lifetime maximums or

dollar caps varies by state. School districts need to be aware of lifetime caps and to request families to examine their policy and become aware of any coverage limitations. There is no way to know the status of a child's insurance benefits without reviewing the policy.

A school district can be liable for funds received through insurance reimbursement and later needed by families when their policies contain lifetime maximums or caps. The United States Court of Appeals recently ruled that a mentally handicapped woman could sue to recover insurance funds that were paid to a residential facility for care that should have been paid by the school district.[1]

School districts need to develop and communicate policies in regard to access and use of insurance dollars when families' lifetime caps may be affected. Districts can provide written statements, for example, regarding maximums they will access during a school year and written guarantees to families promising repayment of funds when lifetime caps are threatened or funds are needed by other health providers in later years.

Recently, some insurance companies have attempted to deny payments to school districts on the basis that families cannot have incurred a loss when school districts are obliged to provide a free appropriate public education. Standard indemnity insurance contracts are written to indemnify the insured (family) from a financial loss (claim for services). Insurance carriers may deny claims on the basis that the family does not truly incur a loss because it is not obligated to pay for related services by federal law.

Historically, in the states in which school districts have billed for special education related services, insurers have paid viable claims that are outlined in their policy benefits. The position that the free and appropriate services provided by school districts do not substantiate a financial loss to an insured is new. In the states where insurance companies have denied claims on this basis, it will take legal precedent to resolve this issue.

B. Will Parents Allow School Districts To Access Their Third Party Payor for Services Provided as Part of Their Child's IEP?

Parents of students with handicaps are not legally obligated to allow school districts to access their third party coverage. The information provided by school districts currently accessing families' coverage in Minnesota, Illinois, Connecticut and Missouri, however, indicates that most families have allowed districts to access their insurers when guarantees are provided regarding depletion of lifetime policy maximums and caps.

It is advantageous to families to allow the district to access their insurance because the district is then responsible for coinsurance and deductibles the families would normally incur. School districts have also been successful in accessing third party reimbursement when families of special education students understand the potential benefits to their child of such an arrangement.

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[1] *Shook v. Gaston County Board of Education*, 882 F.2d 119 (4th Cir. 1989), *cert. denied*, 58 U.S.L.W. 3528 (1990).

One family's experience with the use of third party reimbursement indicated that their child was not demonstrating the progress warranted by the amount of therapeutic services received. As a result the family requested the district to decrease the services and re-evaluate their child's educational plan. In this case, the district's access of third party reimbursement prompted the parents to review the costs of the services their child received. The parents and the multidisciplinary team then made the determination that the costs were extreme in relation to the benefits to the child. Prior to the access of their insurance, the parents of this child had not been aware of the costs of their child's related services. In this case the parents and the school district became better consumers because of their heightened awareness of the cost of special education services.

When districts choose to access third party reimbursement, they are required to complete progress summaries on a more frequent basis than is otherwise required by federal education regulations. This increased documentation of progress, in combination with the increased benefits special education students may receive through increased funding and the districts' responsibility to absorb deductibles and coinsurance, provide good motivation for families of students with handicaps to allow access of their insurance benefits.

Research and the trends in education indicate there will be increased pressure from parents of students in regular education programs for districts to seek alternative funding sources to support special education. Parents of regular education students have voiced concern regarding the increased costs and space requirements of special education programs since education has obtained the responsibility for children ages birth through 21 in some states. This population has also noted that students with special needs are provided special education preschool programs that include transportation, while they pay for preschool programs and day care and provide their own transportation. Parents of regular education students may influence the parents of special education students to assist in any way possible to secure increased funds to maintain and improve special education services.

C. Will the Decision for Services Be Based on the Availability of Third Party Reimbursement and Can Services Be Withheld Pending Third Party Reimbursement?

There is a fear that services may be withheld or delayed based on the availability of third party reimbursement. On the other hand, the issue of increased services due to the availability of additional funding is also of concern—to providers, payors and families.

The Medicare Catastrophic Health Care Act[2] specifically indicates that needed services must be outlined on a child's IEP. Federal law mandates that the IEP be the driving force within the special education system. Withholding of services included in a child's IEP on the basis of third party reimbursement was declared illegal by the U.S. Department of Education.[3] The Department's Office of Special Education Programs specifically stated that

[2] P.L. 100-360, 102 Stat. 683

[3] Policy Letter in response to John Conway, 1986-87 *Education for the Handicapped Law Report* 211:438 (1987).

the provision of services cannot be based on third party payment or withheld while a claim was being filed.

School districts' inflating the services outlined on IEPs also does not make sense. It would not benefit a district to develop an IEP and outline increased or inflated amounts of services based on the presumption that a child's third party payor will reimburse for those services because, legally, once the services are outlined on a child's IEP they must begin as outlined and they must be provided at the frequency specified. Thus, a school district that outlines increased services on an IEP is obligated to provide those services regardless of reimbursement. The district must have both the staff and means available to provide the services whether or not increased funding is obtained.

Since families change insurance carriers and employment settings often, a school district is not likely to know whether the child has the same insurer, policy or benefits each calendar year. A child's eligibility for Medicaid can in fact change on a monthly basis due to family crisis, financial status shifts, foster care needs or alternative living arrangements. Thus, school districts have to monitor third party payor coverage more frequently than on an annual basis. Yet they must continue to allow the child's needs and the development of an individual education plan to drive the system, not the availability of third party reimbursement. School districts cannot withhold initiation of services once those services are outlined on an IEP.

D. Third Party Payors Require Access to Patient Information. How Does This Affect Data Privacy and the Adequacy of Parental Consent?

The federal regulations that enforce the Family Educational Rights and Privacy Act (FERPA)[4] clearly indicate that information may be disclosed only with the consent of parents, except when highly unusual circumstances exist. Parents have the right to refuse consent—a fact many parents may not know—yet a child whose parents refuse such consent cannot be denied services or provided less service.

Parental consent to disclose information must specify the records that are to be disclosed, the purpose of the disclosure and the party or entity to whom the disclosure is to be made. Parents must sign and date all consent forms. Consent forms should indicate dates of effectiveness. Health care providers routinely request completion of new consent forms at each visit or annually, depending on the type of services provided (physician, hospital or dental, for example).

Adequate documentation regarding parental consent to disclose information and to access third party payor sources is crucial to the success of any third party reimbursement system and to the prevention of legal suits at a later date. School districts need to scrutinize carefully all consent forms and methods for obtaining that consent regarding access of payors. School districts should utilize face-to-face conferences to explain consent forms and require parents or guardians to sign and date all forms. Parents need to be kept aware of the

[4] 34 C.F.R. Part 99.

services provided and the charges submitted and reimbursed by third party payors. If prudent methods are established to include consistent communication and good documentation of consent, legal disputes can be avoided.

E. Will the Availability of Third Party Reimbursement Within the School Setting Provide "One Stop Shopping" for Related Services, Thereby Preventing Other Health Care Sources from Providing Therapeutic Services?

P.L. 100-360 was never intended to establish school districts as the one entity responsible for all related services to children with handicaps. The law specifically states that the related services to be outlined on the child's IEP must be developed to meet the educational needs of that specific child in light of his or her handicapping conditions. School districts currently do not have adequate federal, state and local funds to meet all the needs of all those children. P.L. 100-360 provides districts with an additional source of funding that may be used to assist in defraying the costs of services the district must provide, based on each child's IEP. Strict interpretation of P.L. 100-360 would indicate that related services that are not outlined on a child's IEP would be considered reimbursable by Medicaid. State Medicaid agencies would therefore not be required to reimburse school districts for therapeutic services which are not IEP related unless the district could meet requirements as another existing provider type, such as a clinic or hospital.

If a school district were to choose to establish a health care entity, however, that met the current federal, state and local regulations for a provider such as a rehabilitation agency, hospital or physicians' clinic, it could access third party reimbursement from the payor sources that recognize that entity. School districts have always had that option available, but few have thus far chosen to change practices and hire medical personnel to meet the standards for those provider types.

The general response to access of third party reimbursement by districts throughout the country has, in fact, not been overwhelmingly positive. Most districts share concerns regarding the policy, procedure, documentation and integrative changes necessary to implement a system. So it is unlikely that individual districts will choose to attempt to provide all types of related services to students with and without handicaps on the chance that they may collect additional funds.

The key concern to school districts in regard to this issue is the fact that third party reimbursement is tenuous. Since parents and students change insurers often and benefits of policies may change annually, students may be eligible for Medicaid one month and ineligible the next month. School districts are not likely to recommend increased IEP related services or to establish "medicalized" wings within a school setting to provide extra services that are not IEP related when reimbursement is not guaranteed.

Thus, if a student received physical therapy from the local hospital two afternoons per week prior to the school district's access of third party reimbursement, those services need to continue in that environment after the access of third party reimbursement. The district is not responsible for those non-IEP related services, nor should they be, just because third party reimbursement is available. Districts are federally mandated to provide only special education and related services to students who meet their individual state and local

guidelines for services. The availability of third party reimbursement should not be viewed as a reason to expand services to students who do not currently receive mandated special education related services. Therefore, parents need to be informed that the district cannot provide "one stop shopping" for therapeutic needs. This is not to say, however, that coordination of care and services should not be established and continued among all providers.

F. How Do School Districts Define the Differences Between "Medical" and "Educational" as They Relate to Services and Diagnosis?

IEP related services provided by a school district do not have to be labeled either medical or educational. The question is not an either-or choice. School districts provide related services as part of a child's IEP. If the services are outlined on the child's IEP, they have been determined by the multidisciplinary team to be necessary to meet the child's special education needs. If the services also meet the payor's definition of medical necessity and the school district is a payor-recognized provider, the services may be reimbursable. For the purposes of Medicaid, when a related service meets the definition of medical necessity and is outlined on the child's IEP, the debate regarding medical versus educational becomes mute. The services are "educational" because they are outlined on the IEP and "medical" because they also meet the definition of medical necessity.

Recommendations of the type, frequency and duration of services may differ between the school district setting and the health care industry. School districts develop IEPs to meet special education needs and outline the frequency and duration of related services based on those needs. The frequency and duration of therapeutic intervention recommended by non-educational health care practitioners may differ from those outlined on a child's IEP. These variations in frequency and duration of services represent differences in the goals and objectives established within each treatment setting. The differences do not make one recommendation wrong and the other right. The individual goals and objectives outlined for the child need to be reviewed as they relate to the services provided.

Legal precedent has been established in regard to the provision of services within a school district setting. The school district cannot be denied payment based solely on the fact that the services are provided in that setting. However, to qualify for reimbursement, school districts must meet the standards established by the individual third party payors.

G. How Will Medical Diagnosis "Labeling" Affect Students?

There is a risk that medical diagnosis "labeling" will affect children for life. Insurance providers use computerized information exchanges to provide claims activity based on a diagnosis. As families change insurers, they may experience loss or denial of coverage based on conditions determined to be "preexisting."

It is therefore crucial that school districts use accurate diagnosis codes when submitting claims. The physician is integral to access of third party reimbursement for related services because physician referral or certification for evaluation and treatment is required for most therapeutic services. School districts should request diagnosis coding from the student's

physician as it relates to the services the physician is authorizing when diagnoses are not already established. Some school districts may rely heavily on physician determined diagnoses; others will use the expertise of the therapeutic service provider for determining the diagnosis code.

For students without accurate diagnosis codes, school districts should indicate, using appropriate ICD-9 coding (see chapter 5 of this publication), that the diagnosis is not specified. The ICD-9 coding system allows the use of the appropriate code to indicate that a diagnosis has not been specified in regard to the services provided.

IMPLEMENTATION AND FUNDING ISSUES

A. How Will the Credential Requirements of Third Party Payors Affect Personnel in the Schools?

Third party payors require specific credential requirements of personnel for reimbursement. The school district, as the enrolled provider, is responsible for ensuring that the services are provided by staff who meet state licensure and/or payor credential requirements.

The availability of third party reimbursement to schools may require districts to modify hiring practices and change standards for personnel providing related services. The credential requirements for third party reimbursement may be more stringent than current standards within individual states. School districts may experience credential discrepancies with such related services providers as speech-language pathologists and licensed school psychologists. The federally established credential requirements are outlined in chapter 4 of this publication. Districts need to ensure that students whose services are eligible for third party reimbursement are not treated differently from those students without that source of reimbursement based on staff credentials. Establishing standardized procedures for services regardless of staff credentials will provide uniform practices.

Individual professions may choose to use the availability of increased funding for special education and related services to upgrade personnel standards. Requests for increased salaries, payment of liability insurance premiums and reimbursement of fees for the additional licensure requirements that access of third party payment may require could be based on the availability of increased funding.

B. Will the Access of Third Party Reimbursement by School Districts Increase the Professional Liability of Individual Providers?

Legal precedent has not been established regarding individual professional liability for services provided within the schools. Thus, professionals providing related services should review current coverage to ensure adequate and appropriate individual professional liability insurance. All school districts carry general liability insurance and districts may wish to obtain information regarding individual liability for dissemination to employed personnel. However, professionals providing services should not rely on liability coverage maintained by the school district to cover them when named individually in a legal suit by a student and/or a student's family. Some education unions provide individual liability coverage for

education personnel as part of their union dues. Furthermore, all the professional associations provide access to individual and group liability insurance for their members. It is incumbent upon individual professionals to assure that they have ample liability coverage.

C. Will Access of Third Party Reimbursement Supplant Other Federal or State Funds?

The federal language and statutory regulations outlined in chapter 1 encourage educational entities to access third party reimbursement. Uncertainty remains, however, regarding the potential reduction of state funds when this source is accessed. The argument has been made that any funds obtained through third party payors should be viewed as local funds and should not supplant state and federal education dollars. Currently, after all, school districts that obtain funds through fund-raising projects and donations do not experience decreases in state and federal education dollars.

The use of third party payments by the school district may influence policy makers in regard to supplanting issues. School districts will need to determine and communicate the way increased funds are spent. Will third party reimbursement be used, for example, specifically for special education purposes or for general education or a particular project? Districts must delineate specific uses for the net funds generated. Parents will ask how the increased funds will be spent and may be more willing to provide access to those funds when assured that their purpose lies solely within the realm of special education.

School districts need to ascertain the policy and philosophies of state education agencies and to lobby state and federal government with regard to this issue. Funds generated through third party payments do not create a "pot of gold," but they do provide an additional funding source to assist in meeting the increased costs of special education and related services. Additional funding sources can provide lower caseloads, more appropriate services and fewer unserved and underserved special education students. State policy administrators and legislators need to be educated regarding the issues, implementation process and costs involved in establishing a third party reimbursement system.

D. Will Third Party Payors Reduce or Eliminate Funding?

Private insurers may attempt to write new policies that eliminate coverage for the related services school districts provide. School districts, state and federal policy administrators, and professional associations need to lobby for legislation to ensure continued payor coverage of services provided by school districts. The argument has been voiced that related services provided by school districts will increase costs to insurers. However, insurers have historically reimbursed for related services to children with handicaps prior to school districts' implementing services for children ages birth through 21. To date, the author knows of no insurance carrier that decreased premiums when education expanded its services for handicapped students to include children ages birth through four.

Health Maintenance Organizations (HMOs) may attempt to limit reimbursement to school districts by preventing districts from enrolling as preferred providers. Communication with the regulatory agencies that administer HMOs within each state will provide districts with the parameters that govern the operation of local HMOs. To avoid their exclusion school

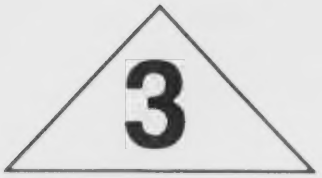
districts may need to lobby regulatory agencies and legislators regarding equal access for all providers of services.

The coverage of special education related services by Medicaid varies dramatically by state, as described in chapter 6 of this publication. Some states have embraced the concept of reimbursement to schools and have established sound policies and procedures. Other states are still reviewing the issues and determining if coverage is appropriate within their current system.

Individual state and federal Medicaid budgets are in financial crisis. Some state Medicaid programs will choose not to reimburse schools for related services if the option exists. This determination will not be made on need but on budgetary implications.

There are several ways for states to fund reimbursement of related services to school districts through the use of currently allocated state and local funds. Oregon, for example, has not increased its state Medicaid budget to cover reimbursement of related services to the schools, but it is using state special education funds to cover the 37.05 percent state portion of the Medicaid costs. Oregon currently receives 62.95 cents of each Medicaid dollar from federal Medicaid funds and must allocate 37.05 cents from state Medicaid funds. The use of currently allocated state and local funds combined with federal Medicaid dollars is one method of providing increased funds for IEP related services without increasing state costs.

This chapter only serves to highlight the major issues that surround the access of third party reimbursement by school districts. The issues are complex, and the answers to many remain unknown. The realm of special education is moving forward with increased costs and additional obligations to serve the needs of all students with handicapping conditions. The strategies for moving past the issues may provide assistance to districts as they decide whether or not to implement a third party reimbursement system and how to establish their policies and objectives for the implementation process when they decide to do so.



State Activities and Resources

The activity of education agencies and state departments of education in regard to the access of third party payors varies from state to state. At one end of the continuum, there are a number of education agencies that have sought third party reimbursement from insurance sources for many years. There are some states that have amended legislation to mandate access of third party reimbursement. There are others that have taken a "wait and see" attitude.

States' abilities to access Medicaid for special education related services are variable. Each state receives a percentage of their Medicaid funds from the federal government. The percentages that states receive differ and are determined by a complex formula established by the Health Care Financing Administration (HCFA) on an annual basis.

The following summary represents activity by states regarding Medicaid and education agencies as of July 1990. The summary includes, among other things, information about the amount of federal medical assistance percentage allocated to each state during 1990.[1] It also includes education agency sources, the names of which were obtained from "Summary of States' Activity Related to Medicaid and Third Party Reimbursement: A Report of a Survey of SEAs," conducted by Linda Duncan Malone.[2] (Information and lists of resources pertaining specifically to the access issues of Medicaid by individual state are found in chapter 6.)

ALABAMA

History and current status: Alabama expects to begin accessing Medicaid for related services during the 1990-91 school year. The Alabama Departments of Education (DOE),

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1 "Medicaid Services State by State," Division of Intergovernmental Affairs, HCFA Publication No. 02155-90 (1989).

2 Indiana Department of Education for the National Association of State Directors of Special Education, April 1990.

Medicaid and Mental Health have been discussing the issues. The DOE is providing matching funds for Medicaid use and has established a task force to sort through issues and assist in the access of private insurance.

Alabama's Medicaid program does not reimburse for the optional services of physical and occupational therapy; speech, hearing or language disorders; or rehabilitation services. The Alabama Medicaid State Plan is in revision in order to allow school districts to bill for related services. The 1990 Federal Medical Assistance Percentage (FMAP) = 73.21.

Education agency resources and contacts: Barry Blackwell
(205) 242-8114

ALASKA

History and current status: Alaska is in the process of reviewing the issues as they relate to third party reimbursement and the access of Medicaid funds. The DOE has identified Anchorage schools as pilot sites for initial access of third party reimbursement and is considering regional billing sites. The 1990 Federal Medical Assistance Percentage (FMAP) = 50.00.

Education agency resources and contacts: Richard H. Smiley, Ph.D.
(907) 465-2970

Other resources: Monica Ferguson, Speech-Language Pathologist
428 Droze Drive, Fairbanks North Star Borough School
Fairbanks, Alaska 99701

ARIZONA

History and current status: Arizona has recently begun to study the issues. The Arizona DOE has established a team to investigate possible implementation of a third party billing system to Medicaid and private insurance. Arizona Medicaid is unique. Arizona operates a federal assistance program under a Section 1115 Demonstration Project. Arizona Medicaid provides only for those identified as categorically needy (CN). The 1990 Federal Medical Assistance Percentage (FMAP) = 60.99.

Education agency resources and contacts: Judy Weaver
(602) 542-3184

ARKANSAS

History and current status: Arkansas has implemented a billing system to access Medicaid for physical and occupational therapy and speech language pathology services. Private insurers have not been billed to date. The governor of Arkansas mandated the DOE and Department of Human Services (DHS—Medicaid) to establish a system between state and federal monies to facilitate reimbursement. The DOE bills the school districts for a 25 percent match and then reimburses Arkansas Medicaid. To date, only the larger school

districts have applied to Medicaid as providers for reimbursement. The 1990 Federal Medical Assistance Percentage (FMAP) = 74.58.

Education agency resources and contacts: Donald Watkins
(501) 682-4220

Other resources: Jess Dancer, Ed.D. Professor
Audiology and Speech Pathology
University of Arkansas at Little Rock
2801 South University
Little Rock, Arkansas 72204

CALIFORNIA

History and current status: California has implemented billing for special education and related services in 15 school districts for private insurance reimbursement only. The California Medicaid program reimburses physical and occupational therapy, speech-language pathology, and audiology on a prior authorization basis except for an initial and six-month evaluation. Reimbursement is provided on a fee-for-service basis. In June 1989, the California DOE funded a proposal from the California Research Institute for a three-year project to develop a method whereby California school districts could elect to provide MediCal (California Medicaid) reimbursable services to handicapped children enrolled in their districts. In August 1989, phase I of the study was completed by Martin Gerry of the Institute and the report was published.[3] The report indicated that the decision to access Medicaid for special education and related services provided to children with handicaps would need to be considered on a district-by-district basis. It indicated further, however, that school districts in California were also eligible to collect Medicaid reimbursement for health related services provided to non-handicapped children. The potential financial gains from access of Medicaid for these services were presented. The 1990 Federal Medical Assistance Percentage (FMAP) = 50.00.

Education agency resources and contacts: Shelly Harris
(916) 323-4727

Other resources: Kenneth E. Wolf, CCC-A
Hearing and Language Specialists
17350 Bronte Place
Granada Hills, California 91344

COLORADO

History and current status: The Colorado DOE is exploring the issues regarding access of third party reimbursement. A report is being prepared for the legislature and a pilot program for access of Medicaid for specific services has been proposed. The Department of

[3] "An Analysis of the Feasibility of Providing Medi-Cal Reimbursement 'Related Services' to Children with Exceptional Needs in California Public Schools."

Health's Services for Children with Handicaps program currently bills private insurers and Medicaid for services provided by that agency to children. Colorado Medicaid does not reimburse for the optional services of physical and occupational therapy; speech, hearing or language disorders; or rehabilitative services. The 1990 Federal Medical Assistance Percentage (FMAP) = 52.11.

Education agency resources and contacts: Fred Smokoski
(303) 866-6694

Other resources: Daniel Gossett, Director
Family and Community Health Services Division
Colorado Department of Health
4210 East 11th Avenue, Denver, Colorado 80220
(303) 331-8360

CONNECTICUT

History and current status: The Connecticut DOE established an interagency agreement with the Department of Income Maintenance (Medicaid) in 1983. All billing by participating school districts is handled through one of the state's regional educational service centers, which operates as a central billing agent. Districts that participate must meet the following criteria: (1) each individual clinician must be independently enrolled with Medicaid. (2) Districts must contact parents of Medicaid-eligible children and obtain permission to bill third party payors. Family participation is strictly voluntary. (3) Each participating district must submit a written plan to the State Board of Education outlining its billing system operations. Once districts are qualified, each service plan is physician reviewed and then services are provided as outlined in the district's operating plan and are documented on forms provided by the central billing agent. All forms are submitted to the central billing agent for processing. Each school pays all co-payments and deductibles required by an insurer.

Approximately $300,000 was collected during the 1987-88 school year and approximately $550,000 during the 1988-89 school year. The funds collected were from both Medicaid and private insurance sources. Initial problems with the Connecticut system included resistance by service providers regarding the increased paperwork and documentation requirements. Resistance has decreased significantly since staff have observed benefits of the system, however. The benefits reported include: supportive parents; payment of family deductibles for private insurance; parents' increased understanding of the nature and extent of services; and increased physician participation and knowledge regarding the IEP process.

The Connecticut legislature enacted a law, effective July 1, 1989, which permits Medicaid payment to the schools.[4] The Connecticut Department of Income Maintenance (Medicaid) has developed rules for "school-based child health services," which—among other things—outline the scope and limits of reimbursable services. The 1990 Federal Medical Assistance Percentage (FMAP) = 50.00.

[4] Public Act No. 89-135

Education agency resources and contacts: Patrick Shawnessy
(203) 638-4246

Other resources: Capital Education Council
School-Based Child Health Services Project
599 Matianuck Avenue
Windsor, Connecticut 06095
(203) 683-2265

DELAWARE

History and current status: There has been no initiation of a third party reimbursement system to date. Delaware Medicaid does not currently reimburse for the optional services of physical and occupational therapy or speech, language, hearing or rehabilitation services. The DOE has initiated meetings with Medicaid to determine possible options within the current Medicaid state plan. Strategic planning also includes involvement of the state insurance commissioner to negotiate with private insurance regarding coverage. There is currently, however, a major medical center that provides resources on referral. The 1990 Federal Medical Assistance Percentage (FMAP) = 50.00.

Education agency resources and contacts: Carl Haltom
(302) 736-5471

DISTRICT OF COLUMBIA

History and current status: Currently there is no information regarding education agency initiatives toward a third party pay system. The District of Columbia Medicaid program reimburses speech pathology, physical and occupational therapy, and rehabilitation for both the medically and categorically needy. Reimbursement is made only to outpatient hospital providers and home health agencies, however, on a fee-for-service basis. The current state plan does not allow independent providers and rehabilitation agencies to enroll. The 1990 Federal Medical Assistance Percentage (FMAP) = 50.00.

Education agency resources and contacts: Doris Woodson
(202) 724-4018

FLORIDA

History and current status: There is no initiation of a third party reimbursement system by education agencies to date. The DOE plans to investigate the issues with third party payors and Medicaid in 1990. Current plans include hiring a consultant to the DOE. The current Medicaid state plan does not reimburse for the optional services of physical and occupational therapy or speech, language and hearing services. Medicaid does reimburse rehabilitation agency providers, however. The 1990 Federal Medical Assistance Percentage (FMAP) = 54.70.

Education agency resources and contacts: Lee Clark
(904) 488-1379

GEORGIA

History and current status: There is no initiation of a third party reimbursement system by education agencies to date. The current Medicaid state plan does not reimburse for the optional services of physical and occupational therapy; speech, language and hearing disorders; or rehabilitation services. The 1990 Federal Medical Assistance Percentage (FMAP) = 62.09.

Education agency resources and contacts: Sam Scott
(404) 656-2425

HAWAII

History and current status: There is no initiation of a third party reimbursement system by education agencies to date and no plans to seek that form of funding in the future. The current state Medicaid plan does reimburse for the optional services of physical and occupational therapy; speech, language and hearing disorders; and rehabilitation services. Medical agencies are the recognized providers of these services. The 1990 Federal Medical Assistance Percentage (FMAP) = 54.50.

Education agency resources and contacts: Richard Isa
(808) 548-5554

IDAHO

History and current status: There is no initiation of a third party reimbursement system by education agencies to date, but Idaho is reviewing the issues with Medicaid and insurance agencies. The current Medicaid state plan does not reimburse for the optional services of physical and occupational therapy or speech, language and hearing services. Reimbursement is provided for rehabilitation services for the categorically needy. The 1990 Federal Medical Assistance Percentage (FMAP) = 73.32.

Education agency resources and contacts: Mike Louder
(208) 334-3940

ILLINOIS

History and current status: Currently there are no formal guidelines or policies in regard to third party reimbursement by the DOE, but individual districts and regions have been accessing third party payor sources since 1988. The regional education services center, which established the initial third party billing system in Illinois in cooperation with a billing agent (TAMES), indicates success in accessing third party payors (private insurance and Medicaid) for increased funding for special education and related services. State legislation has been drafted to mandate a "study" of the issue and to review Medicaid reimbursement and state plan changes. Illinois Medicaid does reimburse physical and occupational therapy; speech, language and hearing services; and rehabilitation services for

both the medically and categorically needy. The 1990 Federal Medical Assistance Percentage (FMAP) = 50.00.

Education agency resources and contacts: Von Morrison
(217) 782-6601

Other resources: Cheryl L. Anderson
Vice President, Illinois Speech-Language-Hearing Association
United Way Building
730 East Vine Street
Springfield, Illinois 62703
(217) 789-1876

INDIANA

History and current status: Schools are currently not accessing third party payors. The DOE has initiated a study of the issues and formed a task force, which includes Medicaid and affected agencies. A pilot study has been planned for fall 1990. Indiana Medicaid does reimburse for physical and occupational therapy; speech, language and hearing services; and rehabilitation services for the categorically needy only. The 1990 Federal Medical Assistance Percentage (FMAP) = 63.76.

Education agency resources and contacts: Linda Duncan Malone
(317) 232-0570

IOWA

History and current status: The Iowa DOE was legislatively mandated in 1988 to develop a plan for area education agencies to access Medicaid reimbursement for physical and occupational therapy; psychological and audiological evaluation; and speech language services. There were no guidelines initially developed except that services for all Medicaid-eligible students be billed to Medicaid.

The federal portion of the funds generated through billing Medicaid is returned to the state's general fund. In return for establishing the system and processing the bills, the area education agencies are allowed to retain a minimal percentage of the state portion of the Medicaid funds. The reimbursement by Medicaid for the services provided has been established by legislative mandate at a low rate, however, and the education agencies have found that the costs are greater than the amount retained. In 1990, therefore, Iowa passed a new state law,[5] which increased by 4 percent the amount area education agencies are allowed to retain for processing bills. Iowa Medicaid currently reimburses for both the medically and categorically needy for physical and occupational therapy, speech-language pathology, audiology and rehabilitative services. The 1990 Federal Medical Assistance Percentage (FMAP) = 62.52.

[5] S.F. 2324 (1990) (effective July 1, 1990).

Education agency resources and contacts: Jean Ann Hagen
(515) 281-3176

Other resources: Donna DeShaw
1215 North Adams
Carroll, Iowa 51401
(712) 792-1265

Barb Momberg, Program Specialist
Iowa Department of Human Services
Hoover State Office Building
Des Moines, Iowa 50319-0114

KANSAS

History and current status: Kansas Medicaid has revised the state plan to allow school districts to access Medicaid. There are five pilot districts prepared to begin third party reimbursement systems. The plan has established one district to bill for all those in the pilot. The amount of Medicaid or insurance reimbursement collected is unknown, to date. The 1990 Federal Medical Assistance Percentage (FMAP) = 56.07.

Education agency resources and contacts: Judy Cutsinger
(913) 296-4943

KENTUCKY

History and current status: Individual school districts began to access insurance sources for special education and related services in 1989. Fayette County schools and other area education agencies have contracted with a local billing agent (LEARS) to access private insurers for IEP related services. Kentucky Medicaid has revised its state plan to allow schools to bill for specifically defined services. Medicaid expects state plan approval in summer 1990, and school districts expect to access Medicaid funds during the 1990-91 school year. The Kentucky State Education Agency will act as a facilitator and allow area education agencies to establish individual billing systems. The 1990 Federal Medical Assistance Percentage (FMAP) = 72.95.

Education agency resources and contacts: Linda Hargan
(502) 564-4970

LOUISIANA

History and current status: Louisiana has implemented a third party reimbursement system to access both Medicaid and private insurance sources. Each "parish" (education agency) may choose to bill individually or to use the billing agent selected by the state (Health Management Concepts). Approximately half of the parishes bill independently

and half contract with the agent. The 1990 Federal Medical Assistance Percentage (FMAP) = 73.12.

Education agency resources and contacts: Henry Smith
(504) 342-3631

MAINE

History and current status: Access of third party reimbursement has not been implemented in Maine. Several studies are currently underway by Medicaid, the Department of Education, and Child Development Services to identify options, procedures and implementation strategies for access of third party reimbursement. The Maine Division of Special Education plans to implement access of all third party reimbursement sources by July 1991. The 1990 Federal Medical Assistance Percentage (FMAP) = 65.20.

Education agency resources and contacts: David N. Stockford
(207) 289-5950

Other resources: Deborah Parker-Wolfenden, Consultant
RR 4, Box 4325, Freeport, Maine 04032
(207) 688-4809

MARYLAND

History and current status: Maryland has implemented a third party reimbursement system in the Baltimore city school system only. The Baltimore City Public Schools provide "special education health care services" and operate this program as a "health clinic." A statewide effort coordinated by the DOE has not yet been implemented. Maryland Medicaid reimburses for both categorically and medically needy physical therapy and speech, language, hearing and rehabilitative services. The 1990 Federal Medical Assistance Percentage (FMAP) = 50.00.

Education agency resources and contacts: Vira Froehlinger
(301) 333-2439

MASSACHUSETTS

History and current status: Massachusetts developed statewide early intervention programs under the auspices of the Department of Health in 1983. These programs were established as nonprofit entities and specifically defined services are reimbursable by Medicaid. Early intervention services provided by these recognized Medicaid providers are reimbursed on a fee-for-service basis. The Massachusetts Medicaid program amended the Clinic Services option of their state plan to allow for reimbursement for these early intervention services. The use of federal Medicaid funds to pay for health related services provided within an educational setting was upheld in 1988.[6] School districts within

[6] *See Bowen v. Massachusetts*, 487 U.S. 879, 108 S. Ct. 2722 (1988).

Massachusetts currently contract for therapeutic services with outside vendors, who then access third party payors.

The Massachusetts legislature enacted a bill in January 1990 mandating private insurance coverage for early intervention services. The new law requires insurance companies to cover a range of "medically necessary" early intervention services (including occupational and physical therapy, speech-language pathology, nursing care and psychological services) that are provided by licensed personnel working in programs certified by the Department of Public Health. The law requires payment of $2,400 per year per child ages birth through three. There is a maximum "cap" of $8,000 for early intervention services, which does not count towards the family's basic health insurance maximums. Medicaid reimburses for both the medically and categorically needy in the areas of physical and occupational therapy, speech-language pathology, audiology and rehabilitation. The 1990 Federal Medical Assistance Percentage (FMAP) = 50.00.

Education agency resources and contacts: Lisa Zieg
(617) 770-7468

Other resources: Karl Kastorf
Department of Public Health
150 Tremont Street
Boston, Massachusetts 02111
(617) 727-5089

MICHIGAN

History and current status: Michigan has implemented one pilot project to access Medicaid and insurance sources. The Michigan DOE hired a consultant to ensure that all state departments maintain current levels of resources, assist schools in provider and credential requirements, develop policy and procedures, and establish a functional system. Expansion of the pilot program is expected in the 1990-91 school year, and Michigan expects to use a billing agent to produce claims. Michigan Medicaid reimburses for both the medically and categorically needy in the areas of physical and occupational therapy, speech-language pathology, audiology and rehabilitation. The 1990 Federal Medical Assistance Percentage (FMAP) = 52.54.

Education agency resources and contacts: Janice Beelan
(517) 373-1695

MINNESOTA

History and current status: Individual school districts, cooperatives and education agencies have implemented third party billing systems as of September 1989. Minnesota Medicaid recognized the need for legislative and state plan changes in 1988. An independent consultant was hired by the Departments of Education and Human Services to develop policy and procedures to allow school districts to enroll as providers and to bill for IEP related services. The Medicaid state plan was changed and legislation was enacted in 1989,

to allow school districts to enroll as providers of physical and occupational therapy, speech-language pathology, audiology, psychological services, medical consultation and complex nursing services. The DOE provided education and training to interested districts and produced a "how to" manual for school districts. The DOE funded a study to ascertain the type and number of related services currently provided in Minnesota in 1989 and 1990. The results of the first phase of the study are available from the DOE.

Reimbursement for services provided to Medicaid recipients was established at the same rates as similar provider types. Medicaid provided training sessions regarding credential requirements, provider enrollment, and documentation to all interested education agencies and billing agents. Minnesota Medicaid reimburses for both medically and categorically needy in the areas of physical and occupational therapy, speech-language pathology, audiology and rehabilitation. The 1990 Federal Medical Assistance Percentage (FMAP) = 52.74.

Education agency resources and contacts: Nevin Nolder
(612) 296-8586
(612) 296-4163

Other resources: Roberta A. Kreb
7980 Ranchview Lane North
Maple Grove, Minnesota 55369
(612) 420-3214

Howard Abrahamson
20500 Harlow Avenue
Jordan, Minnesota 55352
(612) 492-2129

MISSISSIPPI

History and current status: Mississippi has reviewed the issues and amended the Medicaid state plan to allow school districts to bill for special education related services. State legislation passed in 1989 allows access of third party reimbursement: "The State Department of Education is hereby authorized to match minimum program funds allocated for provision of services to handicapped children with Division of Medicaid funds to provide language-speech services, physical therapy and occupational therapy to handicapped students."[7] Implementation of a third party reimbursement system is expected by the 1990-91 school year. Currently Medicaid reimburses for only those identified as categorically needy. The 1990 Federal Medical Assistance Percentage (FMAP) = 80.18.

Education agency resources and contacts: Lynn Morehead
(601) 359-3498

[7] S.B. No. 2467 (1989) (effective July 1, 1989).

MISSOURI

History and current status: Several large school districts in Missouri have been accessing insurance reimbursement since 1987. The school districts actively seeking third party reimbursement have used knowledgeable billing agents (Allied Medical Reimbursement Services) and have established systematic procedures for access of insurance dollars. One large district in Independence, Missouri, for example, has established a successful system by giving full consideration to the legal and ethical issues involved and providing parents and families of students with detailed information regarding the third party billing system.

Missouri Medicaid has refused to allow school districts to enroll as providers of Medicaid services, however, based on their current categories of provider types. School districts are attempting to enroll as providers through the EPSDT program, thereby eliminating the necessity to change the state Medicaid plan. The 1990 Federal Medical Assistance Percentage (FMAP) = 59.18.

Education agency resources and contacts: Graham Williams
(314) 751-3561

Other resources: Dr. Jim Caccamo, Director of Special Education
Independence Public Schools
1231 South Windsor
Independence, Missouri 64055

James Vigliaturo, Jr.
Allied Medical Reimbursement Services
1200 Board of Trade Center
4900 Main Street
Kansas City, Missouri 64112
(816) 753-2939

MONTANA

History and current status: During the 1989-90 school year Montana implemented a pilot project involving three large districts and one special education cooperative. The pilot project is currently seeking third party reimbursement from Medicaid and other third party payors. Montana studied the issues and the DOE coordinated implementation with Medicaid personnel. Montana Medicaid reimburses for both the medically and categorically needy in the areas of physical and occupational therapy, speech-language pathology and audiology. The 1990 Federal Medical Assistance Percentage (FMAP) = 71.35.

Education agency resources and contacts: Robert Runkel
(406) 444-3095

NEBRASKA

History and current status: The Nebraska legislature mandated a feasibility study, which determined that the DOE and individual districts should **not** pursue Medicaid and third party reimbursement at the present time. Instead, the DOE is attempting to access Medicaid through innovations within the EPSDT program. Medicaid reimburses for both categorically and medically needy physical therapy and speech, hearing and language disorder services only. The 1990 Federal Medical Assistance Percentage (FMAP) = 61.12.

Education agency resources and contacts: John Clark
(402) 471-2471

NEVADA

History and current status: The DOE has begun to study the issues and assess the state's current status in regard to third party reimbursement. A third party reimbursement system has not been implemented in Nevada. Medicaid reimburses for categorically needy physical and occupational therapy and speech, hearing, language and rehabilitative services only. The 1990 Federal Medical Assistance Percentage (FMAP) = 50.00.

Education agency resources and contacts: Jane Early
(702) 885-3140

NEW HAMPSHIRE

History and current status: A bill that was initiated in the House in March 1989, but failed to pass would have implemented third party reimbursement initiatives within New Hampshire. The Departments of Health and Human Services and Education, as well as local school district representatives, have formed a committee to resolve the issues that remain during the 1989-90 school year. Prior to enrollment of school districts as Medicaid providers, the Medicaid state plan will need to be amended and legislative changes will need to be enacted. It is the goal of the committee to allow all interested school districts to participate in the Medicaid program. New Hampshire Medicaid reimburses for both the medically and categorically needy for physical and occupational therapy, speech-language pathology, audiology and rehabilitative services. The 1990 Federal Medical Assistance Percentage (FMAP) = 50.00.

Education agency resources and contacts: Jane Weissmann
(603) 271-3741

NEW JERSEY

History and current status: The New Jersey DOE has indicated no interest in access of third party reimbursement at this time. Staff of both the Special Education Division of the DOE and the Department of Health participated in Karl White's federally funded consortium which produced a national study of the issues in 1989. Consideration has been given to hiring a staff person to review the issues and develop a policy in regard to Medicaid. New

Jersey Medicaid reimburses for both the medically and categorically needy for physical and occupational therapy, speech-language pathology, audiology and rehabilitative services. The 1990 Federal Medical Assistance Percentage (FMAP) = 50.00.

Education agency resources and contacts: Arlene Roth
(609) 292-7604

Other resources: New Jersey Department of Health
Special Child Health Services
120 South Stockton
CN 364
Trenton, NJ 08625-0364

NEW MEXICO

History and current status: New Mexico has not implemented a third party reimbursement system to date. However, the Departments of Human Services, Health and Environment, Youth Authority and Education have formed a joint committee to explore the issues and develop recommendations in regard to a third party reimbursement system for educational providers. New Mexico Medicaid currently reimburses for categorically needy physical therapy, clinic services and rehabilitative services. The 1990 Federal Medical Assistance Percentage (FMAP) = 72.25.

Education agency resources and contacts: Taron Tucker
(505) 827-6541

NEW YORK

History and current status: In July 1989 the New York legislature enacted a law that authorized Medicaid reimbursement to school districts for special education related services and allowed districts to enroll as Medicaid Article 52 Centers. Currently one pilot project has been implemented in the South Huntington School District. Its billing is being done by the BOCES 2 on Long Island. The DOE and the State Department of Social Services are currently developing an agreement regarding state policy and the responsibilities of each agency. New York Medicaid reimburses for both the medically and categorically needy for physical and occupational therapy, speech-language pathology, audiology and rehabilitative services. The 1990 Federal Medical Assistance Percentage (FMAP) = 50.00.

Education agency resources and contacts: Jim DeLorenzo
(518) 474-5548

Other resources: Mary Ann O'Brien
New York State Speech-Language-Hearing Association
111 Washington Avenue
Albany, New York 12210

NORTH CAROLINA

History and current status: A pilot project will be implemented by 16 school districts during the 1990-91 school year to access Medicaid and other third party payors. The North Carolina state plan is being revised both to allow coverage of related services and to enable school districts to enroll as providers. Currently, North Carolina Medicaid reimburses for medically and categorically needy rehabilitative services only. The 1990 Federal Medical Assistance Percentage (FMAP) = 67.46.

Education agency resources and contacts: Jim Barden
(919) 733-3921

NORTH DAKOTA

History and current status: North Dakota school districts have implemented a third party reimbursement system. The Departments of Education and Human Services developed policies and procedures cooperatively. Special education units, recognized as Medicaid providers, bill directly to the Department of Human Services. North Dakota Medicaid reimburses for both the medically and categorically needy for physical and occupational therapy, speech-language pathology, audiology and rehabilitative services. The 1990 Federal Medical Assistance Percentage (FMAP) = 67.52.

Education agency resources and contacts: David Zentner
(701) 224-2321

OHIO

History and current status: Ohio school districts have not implemented a third party reimbursement system to date. State legislation is being drafted and the Medicaid state plan is being revised to allow school districts to access Medicaid directly. The Ohio Medicaid program reimburses physical and occupational therapy, speech-language pathology, audiology and rehabilitative services. The 1990 Federal Medical Assistance Percentage (FMAP) = 59.57.

Education agency resources and contacts: Ed Kapel
(614) 466-2650

OKLAHOMA

History and current status: Oklahoma has not implemented a third party reimbursement system to date. The DOE is researching alternative funding sources for early intervention services and has developed definitions and guidelines in regard to Medicaid reimbursement. Oklahoma state law currently precludes any payment from one state department to another, however. Oklahoma Medicaid reimburses for medically and categorically needy rehabilitation services only. The 1990 Federal Medical Assistance Percentage (FMAP) = 68.29.

Education agency resources and contacts: Connie Siler
(405) 521-3351

OREGON

History and current status: The Oregon DOE has obtained a full-time consultant through the Medicaid program to assist in policy and procedure development to enable districts to establish and operate third party reimbursement systems. The Oregon billing systems will be Lead Education Agency based and the education agencies will complete their own forms without use of a billing agent. The Oregon DOE is supplying the state Medicaid dollar match from special education funds, thereby increasing special education funding by the federal match portion only. Oregon Medicaid modified their automated claims system to recognize school districts as providers. Oregon Medicaid also provides local school districts with a list of all Medicaid eligible recipients and has a sophisticated management information system in operation. The Oregon Medicaid program reimburses for both the medically and categorically needy in the areas of physical and occupational therapy, speech-language pathology, audiology and rehabilitation. The 1990 Federal Medical Assistance Percentage (FMAP) = 62.95.

Education agency resources and contacts: Sandra Peterson
(503) 378-1484

PENNSYLVANIA

History and current status: Pennsylvania is currently accessing private insurance sources. The intermediate districts have established third party reimbursement systems and have received reimbursement. The initiatives began with individual school districts and the DOE is now providing support through development of a software program to produce bills and provide a data base system. Access of Medicaid as a reimbursement source, which has not yet been achieved, is expected by 1991. Currently, Pennsylvania does not reimburse for categorically or medically needy therapeutic services of any form except to a provider who meets their definition of a medical clinic. The 1990 Federal Medical Assistance Percentage (FMAP) = 56.86.

Education agency resources and contacts: Brenda Golden
(215) 524-5096

RHODE ISLAND

History and current status: Rhode Island has not initiated any third party reimbursement system to date, but it has established a task force to investigate the issues and provide suggestions for changes to their state Medicaid plan. The Rhode Island DOE expects to have a system established by the 1990-91 school year. Currently, Rhode Island Medicaid reimburses for categorically and medically needy rehabilitative services only. The 1990 Federal Medical Assistance Percentage (FMAP) = 55.15.

Education agency resources and contacts: Robert Pryhoda
(401) 277-3505

SOUTH CAROLINA

History and current status: South Carolina has not implemented a third party reimbursement system to date. The DOE and interagency coordinating councils in South Carolina established a committee to review and address the issues regarding third party reimbursement in 1989. The Medicaid state plan has been reviewed and changes have been suggested. The issues of matching funds, appropriate use of funds collected, and billing procedures have all been addressed. Medicaid currently reimburses for categorically and medically needy rehabilitative services. The 1990 Federal Medical Assistance Percentage (FMAP) = 73.07.

Education agency resources and contacts: Mary Ginn
(803) 737-8710

SOUTH DAKOTA

History and current status: South Dakota has not implemented a third party reimbursement system to date. The state has contracted for a study, however, regarding the issues, viability, and procedures necessary to establish a third party reimbursement system. Medicaid reimburses for categorically needy physical therapy and speech, language and hearing services, only. The 1990 Federal Medical Assistance Percentage (FMAP) = 70.90.

Education agency resources and contacts: Mona Johnson
(605) 773-3678

TENNESSEE

History and current status: Tennessee has not implemented a third party reimbursement system to date. The DOE is aware of the issues but no formal committee has been established to review them or to develop implementation strategies. Tennessee Medicaid does not reimburse for categorically or medically needy therapeutic services. The 1990 Federal Medical Assistance Percentage (FMAP) = 69.64.

Education agency resources and contacts: Sarah Willis
(615) 741-0662

TEXAS

History and current status: Texas has not implemented a third party reimbursement system to date. The Departments of Education and Human Services have formed a committee to discuss the issues and recommend solutions and strategies. Establishing school districts as providers in Texas will require Medicaid state plan changes. Texas Medicaid reimburses for categorically and medically needy rehabilitative services. The 1990 Federal Medical Assistance Percentage (FMAP) = 61.23.

Education agency resources and contacts: Ken Crow
(512) 463-9382

UTAH

History and current status: Services for children ages birth through two are the responsibility of the Department of Health, which has billed both Medicaid and private insurers for some services provided for many years. Services for children ages three to five are the responsibility of the Department of Education. In 1987 the Departments of Health and Education began the development and implementation of a comprehensive system for accessing private third party payors and three programs within Medicaid (EPSDT, Targeted Case Management, and Clinic Services). The Medicaid state plan has been amended to allow school districts to enroll as clinic providers. The DOE is currently attempting to qualify school districts as clinics and to establish billing systems. Utah Medicaid reimburses for both categorically and medically needy physical therapy and speech, language and hearing services. The 1990 Federal Medical Assistance Percentage (FMAP) = 74.70.

Education agency resources and contacts: John Killoran
(801) 538-7708

Other resources: Karl White
Early Intervention Research Institute
Utah State University
Logan, Utah 84322-6580

Peter Van Dyck, Director
Division of Family Health Services
Utah Department of Health
44 Medical Drive
Salt Lake City, Utah 84113

VERMONT

History and current status: Vermont has not implemented a third party reimbursement system to date. Legislation introduced in 1990 that required the use of Medicaid to fund special education related services was not voted out of committee. There are plans to reintroduce the same legislation in the 1991 session. The Vermont DOE has initiated meetings with Medicaid and other state agencies. In order for school districts to bill Medicaid, however, the state plan will need to be revised. Vermont Medicaid reimburses for the medically and categorically needy, physical and occupational therapy, speech-language pathology, audiology and rehabilitative services. The 1990 Federal Medical Assistance Percentage (FMAP) = 62.77.

Education agency resources and contacts: Laurie Gossens
(802) 828-3141

VIRGINIA

History and current status: Virginia has implemented a pilot project within seven counties to bill Medicaid through a private agency and has hired a consultant to explore

issues and provide recommendations to the Departments of Education and Medical Assistance. Virginia Medicaid reimburses for both categorically and medically needy physical and occupational therapy and speech, language and hearing services. The 1990 Federal Medical Assistance Percentage (FMAP) = 50.00.

Education agency resources and contacts: Bill Elsesser
(804) 225-2890

WASHINGTON

History and current status: Legislation was passed in 1989 mandating both a pilot project to access third party reimbursement and a report to the legislature by the 1991 session.[8] The state has established a system to pilot in one educational service district. Washington Medicaid reimburses for both medically and categorically needy in the areas of physical and occupational therapy; reimbursement for speech pathology and rehabilitation, however, are provided in the area of the categorically needy only. The 1990 Federal Medical Assistance Percentage (FMAP) = 53.88.

Education agency resources and contacts: Bob LeGuard
(206) 753-2563

WEST VIRGINIA

History and current status: West Virginia has not implemented a third party reimbursement system to date. The DOE and Medicaid officials are currently discussing the issues with legislators to determine feasibility. West Virginia Medicaid reimburses for both the categorically and medically needy physical therapy and speech, language and hearing services. The 1990 Federal Medical Assistance Percentage (FMAP) = 76.61.

Education agency resources and contacts: Pam George
(304) 348-2696

ISCONSIN

History and current status: Individual school districts have implemented third party reimbursement systems to access private insurance and Medicaid. Some districts have obtained their own provider numbers with Medicaid and others have contracted with billing agents for billing and with private agencies for services and/or billing. The Department of Education has not issued any guidelines regarding either the issues or access, itself. The Department of Public Instruction (Medicaid), however, issued a bulletin in April 1990 indicating that detailed information regarding access of Medicaid by school districts will be provided in September 1990. The Wisconsin Education Agency is encouraging school districts to access insurance and intends to provide appropriate guidelines, resource materials and training during the 1990-91 school year. Wisconsin Medicaid reimburses for

[8] H.B. 2014 (1989) (presumably effective July 1989).

both categorically and medically needy, in the areas of physical and occupational therapy, speech-language pathology, audiology and rehabilitation services. The 1990 Federal Medical Assistance Percentage (FMAP) = 59.28.

Education agency resources and contacts: Paul Halderson
(608) 266-1781

WYOMING

History and current status: Wyoming has not implemented a third party reimbursement system but has begun to investigate the issues to determine feasibility for their state. Wyoming Medicaid reimburses for categorically needy physical therapy and rehabilitative services. The 1990 Federal Medical Assistance Percentage (FMAP) = 65.95.

Education agency resources and contacts: Margie Simineo
(307) 777-7414

Establishing a Third Party Reimbursement System: "Where To Begin"

Establishing a third party reimbursement system will require changes and additions to the current special education process. Many of those changes will be beneficial to the students, the professionals who provide related services and the special education system. Prior to any data gathering, each school district administration should review all the issues that surround third party reimbursement for related services and should develop philosophies and objectives that relate to the students, parents and professional staff.

The philosophy, objectives and attitudes of school district administrators dramatically influence the success or failure of a third party reimbursement system. If the administration has extensive knowledge of the issues and develops strategies for moving beyond them, the third party reimbursement system will be successful. A positive approach to both established objectives and system changes, combined with the rationale for supporting those changes, needs to be expressed publicly from the data-gathering stage through implementation.

Districts may want to consider the following goals when considering implementation of a third party reimbursement system:

- Improvement in the quality, including amount and effectiveness, of special education services provided to students with handicapping conditions.
- Reduction of local and district costs of providing special education services.
- Development of an efficient and effective billing and reimbursement system for those special education services provided to students with handicapping conditions.

Prior to implementation of a third party reimbursement system, school districts will need to gather data and review current systems and resources in order to implement an organized and successful system. School districts will need to review the following parameters prior to implementation:

- The district's current special education process.
- The credentials of professionals providing related services.
- The resources available within the district's community.
- System implementation options.

CURRENT SPECIAL EDUCATION PROCESS

Each school district responds to federally mandated procedures, but, in doing so, districts develop their own forms and procedures. Even though the IEP process is standard within a district, the documentation methods, preparation time by professional discipline (physical therapy, occupational therapy, speech-language pathology and psychology, for example), current models of service, caseload size and curriculum requirements vary. It will be necessary for the school district to review the current process for each type of related service involved.

It is recommended that the administration meet with representatives from each related service discipline to review current practices and needs. If the administration involves related service staff from initiation through implementation, the professionals will retain ownership in the new system and will truly have an impact on the final product.

The administration should not expect related services staff to welcome this new system without conflict. Some staff will see the benefits to their students and themselves immediately, but others will need to be convinced. The more information the administration can provide at the initiation of the process, the smoother the implementation will be.

Districts will need to gather data related to the types and amount of health related services currently being provided. This procedure is simplified if computerized student services information is available. When computerized data is unavailable, the related services professional can provide this information. The district may wish to have staff complete a survey form that can provide information regarding direct services, indirect services, type of services, and so forth.

Although school districts need to develop individualized survey forms that meet their current practice needs, Appendix 4-A provides a simple format for determining direct student service time within current district practices. Surveys should be completed for a time period of no less than two weeks and ideally for at least a month. School districts should request staff to complete these survey forms but not during the beginning or ending of a school year or near vacation periods, because direct service patterns are very different during those time periods. Direct services should be defined as face-to-face treatment time or consultation services provided with the student in attendance.

Once data are collected and reviewed, the district will have a general indication of the amount and type of related services currently provided to special education students. The data do not provide an accurate accounting of the type, frequency and amount of services that will be reimbursed by a third party payor, however. Not all services provided by related

professionals will meet the payor's definition of medical necessity and not all related service professionals will necessarily be considered "qualified" by third party payor standards.

Such a survey of the related services currently provided by the district provides only one piece of information the district may view as necessary to move forward towards implementation. Not all districts will want to take the time to develop and complete a survey, though, and the survey is not an absolute necessity for making a decision. There are, in fact, districts that have implemented third party reimbursement systems without ever surveying staff just as there are districts in current operation whose administration felt it necessary to gather this type of data prior to implementation. If, on the other hand, the survey shows that a district has only a small number of special education students or the model of intervention does not include any direct services that can be documented, implementing a third party reimbursement system may not be feasible.

Regardless of whether or not a district chooses to conduct a survey to determine current practices in regard to related services, the school district and its administration do need a current and pragmatic review of the current district practices should they decide to implement a new procedure because the changes in documentation practices and paperwork and the additional need for third party coverage information will present a considerable challenge for related services professionals.

The chapter on documentation (chapter 8) provides strategies for integration of current procedures with third party reimbursement requirements. What is most important to note here is that the administration needs to involve related services staff early in the process by reviewing their current practices and requesting their input in form development and strategically planned reviews of the system. The involvement of the professionals providing related services at the initiation of the process will lessen conflict later and provide a mechanism for acceptance of any changes to current practices.

CREDENTIALS

Third party payors reimburse only for services provided by professionals who meet their minimum required personnel standards. Third party payors assume that services are provided by "qualified" personnel. Some payors provide written requirements in their contracts with participating provider entities and similar requirements may be outlined in an agreement if a school district contracts with an HMO to provide services. (Details regarding participating provider requirements and methods for obtaining agreements are found in chapter 7 of this publication.)

Most third party payors assume that providers of health related services meet the standards outlined in the Code of Federal Regulations.[1] Because state Medicaid programs receive federal funds, each state program must by law require that qualified personnel meet those standards, which were established by the Health Care Financing Administration (HCFA). The minimum qualifications for physicians, physical therapists, occupational therapists and speech-language pathologists and audiologists, as stated in the Code of Federal Regulations, are as follows:[2]

[1] 42 C.F.R. Section 440.110 (1988).

[2] *Id.*

Physician: [42 CFR 440.50] "Physicians' services," whether furnished in the office, in the recipient's home, a hospital, a skilled nursing facility or elsewhere, means services provided—

(a) Within the scope of practice of medicine or osteopathy as defined by State law; and

(b) By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

[42 CFR 440.110] Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(a) *Physical therapy*. (1) "Physical therapy" means services prescribed by a physician and provided to a recipient by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment.

(2) A "qualified physical therapist" is an individual who is—

(i) A graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent; and

(ii) Where applicable, licensed by the State.

(b) *Occupational Therapy*. (1) "Occupational therapy" means services prescribed by a physician and provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.

(2) A "qualified occupational therapist" is an individual who is—

(i) Registered by the American Occupational Therapy Association; or

(ii) A graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

(c) *Services for individuals with speech, hearing, and language disorders.* (1) "Services for individuals with speech, hearing, and language disorders" means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician. It includes any necessary supplies and equipment.

(2) A "speech pathologist or audiologist" is an individual who—

(i) Has a certificate of clinical competence from the American Speech and Hearing Association;

(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

Psychologist. The qualifications and scope of practice necessary for the delivery of psychological services are not spelled out in federal regulations and thus vary dramatically by state. The current state licensure laws, combined with individual state Medicaid rules,

establish the guidelines for "qualified" personnel in each state. Few state Medicaid programs and other third party payors recognize the credential of a "licensed school psychologist," for the purposes of reimbursement, for example. States *may* license mental health practitioners as "licensed psychologists" or "licensed consulting psychologists."

The credential requirements for a licensed psychologist or licensed consulting psychologist vary, with some states requiring a master's degree for a licensed psychologist and others requiring a Ph.D. for a licensed consulting psychologist. School districts can obtain information about their state's credential requirements by contacting their state Medicaid office, Department of Health or local professional associations.

Professional associations can provide significant information regarding credential requirements and are a valuable resource when initiating and implementing a third party reimbursement system. Professional associations may be able to provide school districts with current local documentation standards, quality assurance parameters and procedures, statistics regarding staff availability, third party payor resources and contacts. National offices often provide policy guidelines and function as resources both to state associations and to individual professional members. Thus the national office for each professional association may also provide information that can be helpful to districts when establishing a reimbursement system.

The following are national office resources:

American Speech-Language-Hearing Association
10801 Rockville Pike
Rockville, Maryland 20852
(301) 897-5700

American Physical Therapy Association
111 North Fairfax Street
Alexandria, Virginia 22314
(703) 684-2782

American Occupational Therapy Association
1383 Piccard Drive
P.O. Box 1725
Rockville, Maryland 20850
(301) 948-9626

National Psychological Association
1200 17th Street N.W.
Washington, D.C. 20037
(202) 955-7600

National Association of Social Workers
7981 Eastern Avenue
Silver Spring, Maryland 20910
(301) 565-0333

National Association of School Psychologists
8455 Colesville Road
Suite 1000
Silver Spring, Maryland 20910
(301) 608-0500

Third party payors will reimburse claims for services provided by professionals who meet the minimum required personnel standards, some of which are outlined in this chapter. School districts can survey personnel to determine the number of professionals currently employed who meet the minimum required personnel standards necessary to access third party payor sources. Appendix 4-B contains a format that may be used to collect this type of data.

The credential survey, as presented, allows for distinction by professional types covering speech-language pathology, audiology, registered physical therapist, certified occupational

therapist, licensed consulting psychologist, licensed practical nurse and school nurse. The paraprofessions of physical therapy assistant and certified occupational therapy assistant are delineated, too. The form also provides information regarding the credential differences among speech-language pathologists and audiologists. For example, a speech-language pathologist may have a master's degree and a Certificate of Clinical Competence (CCC) from the American Speech-Language-Hearing Association or only a master's degree and no CCC. There is also a category for those speech-language pathologists and audiologists completing their Clinical Fellowship Year (CFY), as is required prior to receiving a CCC. This kind of survey enables districts to identify the number and type of professionals whose credentials meet third party payor requirements.

Once data are collected, the district will have an indication of the billing potential for credentialed personnel. For example, if a district has only one speech-language pathologist who holds a master's degree and the CCC credential out of a total of 10 speech-language clinicians, the district can expect to receive reimbursement only for those services provided by the professional with appropriate credentials. These data would indicate to a district that benefit recovery would be limited to only 10 percent of the potential third party reimbursement for speech-language services provided.

Districts that employ a large number of staff who do not meet third party payor credential requirements may want to consider alternate staffing patterns. Other alternatives may include contracting with outside agencies who employ staff with the necessary credentials or modifying future employment practices by limiting new hiring to those who meet the third party payors definition of "qualified."

Third party payors, including some state Medicaid programs, do allow reimbursement for services provided by physical therapy assistants and certified occupational therapy assistants. Payors routinely require the certified physical or occupational therapist to supervise the assistant directly, however, and to certify all evaluations and progress summaries. Some states require 50 percent of the client's visits to have on-site direct supervision, and some limit the number of visits without direct supervision to no more than four or six.

Supervision of non-certified clinicians by master's degree and CCC credentialed speech-language pathologists is not reimbursed by most third party payors. Some state Medicaid programs, such as Arkansas Medicaid, however, do reimburse for speech-language services provided by appropriately supervised non-certified staff.

The costs of alternate staffing patterns, or upgrading staff to meet third party payor credential requirements, are prime considerations prior to system implementation. Regardless of the service delivery model chosen by the district, caution must be exercised to avoid a dual system in which children with handicaps who have third party coverage receive services from personnel who meet the federal credential requirements and those children without coverage are served by personnel who do not meet credential requirements.

RESOURCES

The data and information gathering during initiation and implementation should continue when analyzing the new system's success. Another source of information that can be

valuable to a local school district is a list of the health care facilities that are already accessing third party reimbursement. The health care providers who rely on third party payments to operate have developed the knowledge and skills to work within the health care arena.

Local hospitals, physicians, Medicare rehabilitation agencies, certified outpatient rehabilitation facilities (CORF), insurance agencies and billing agents have all established themselves with the various third party payor sources. Some of these resources may be willing to provide school districts with information or services, or both. Many health care providers, such as hospitals, operate complex computer billing systems and may sell billing services to other health care entities, such as physicians and clinics. School districts can gain the full scope of resources and options available by accessing the local providers within their community.

School district administrations may be hesitant to seek community resources. Districts that are unsure of the reception community providers may give them may wish to establish information sessions with community agencies and providers. Such sessions with established providers offer a functional alternative to individual cold calls and are a good public relations tool when initiating a new program. Furthermore, information sessions allow the school district to meet most of the current health care providers and resource personnel within their community and to seek valuable information.

Community providers need to be reassured that school districts will not supplant the current services provided within established health care facilities, and information sessions provide a functional tool for disseminating this information quickly to a large number of organizations. Districts can use the sessions to inform the community providers about the legal aspects of the district's access of third party reimbursement and its integration within the current educational system.

Districts can also use sessions to seek input from other providers and to solicit their assistance with establishing the district's system. Setting up community partnerships when initiating a third party reimbursement system may simplify the process for school districts. An outline for the scope of questions districts may wish to include when soliciting input from community providers follows.

COMMUNITY PARTNERSHIP PROPOSALS FORMAT

I. Statement of the Agency's Interest
II. Scope of Services the Agency Currently Provides
III. Services the Agency Could Provide in Partnership with the School District
IV. Billing and Reimbursement Experience of the Agency Parameters for Consideration:
- parental consent, insurance and identification forms
- physician authorization process
- documentation procedures
- claims preparation

- claims processing
- collection procedures

V. Experience of the Agency with the Special Education Process

SYSTEM OPTIONS

Prior to implementation of a third party reimbursement system, districts need to establish a mechanism for collection of reimbursement. Districts have several options: direct billing by the district through its own business office, cooperative billing, contracting with a billing agent to bill for services provided by district personnel, and contracting with an established health care entity to provide both billing and services. Before deciding, districts should attempt to identify the most effective and efficient billing and reimbursement system to meet their individual district needs.

Direct Billing

Direct billing by the district providing the services gives the district total control and responsibility for all aspects of the billing and reimbursement system. This method requires the district to learn new methods of operation and to integrate these new methods with the established special education system. There are considerable start-up costs and time commitments with a direct billing system.

Districts with many special education students will want to consider computerization of both the data base and the billing process. Districts will need to incorporate all the medical records and documentation components outlined in chapter 8 of this publication when establishing their billing system. There are existing medical software packages available that can be adapted to meet the school district's system needs. Districts can obtain the necessary information regarding software availability from software vendors and community resources, and they would be wise to contact consultants with expertise in billing and reimbursement to assist with the implementation of a computerized billing system. In addition, districts will either need to employ staff with experience and knowledge in accessing third party payors or to provide extensive training to existing staff.

Development of a computerized third party reimbursement system will require planning and system selection prior to implementation. Reviewing their current computer system and considering its strengths and weaknesses are prerequisites for the school district, prior to identifying specific future applications for the system, including new system requirements. There are knowledgeable software consultants aware of the necessary billing parameters that can assist districts in this planning process. While planning, districts must remember to relate the current student population to growth projections.

Districts that identify potential software packages for purchase should consider the availability of vendor support, software quality and hardware needs. They should consult independent evaluators and interview vendor references. In-house testing of any system should be done prior to purchase. Access of third party reimbursement by school districts is a new venture not just for education, but also for the software vendor.

Implementation of a computerized billing system should be accomplished in a time-phased system that coordinates site preparation, a software implementation plan, a data conversion schedule, development of standard procedures, user training and a personnel plan. Districts should not expect to implement a computerized billing system without consultation and systems assistance from reputable resources within the health care community.

Cooperative Billing

Cooperative billing establishes one cooperative entity, which could be an individual school district, to establish a reimbursement system for several districts. This method provides less risk and responsibility for individual districts and allows the sharing of financial risks. This method requires all those involved to rely on one district, however, to successfully complete all the parameters necessary for implementation and benefit recovery. Like direct billing, cooperative billing will require computerization of the billing process if there is a significant volume of services to be billed.

Contracting Out

Contracting with a billing agent rather than relying on an individual or a cooperative district for claims preparation may be a viable alternative for districts not wishing to commit funding to computerization. Billing agents may include hospitals, clinics, public health agencies, rehabilitation agencies, third party administrator groups, insurance agencies and companies established as billing agents. Billing agents are generally responsible for claims preparation only, but some agents are also involved in documentation and financial reporting form preparation. Billing agents that have added this service have done so to assist districts through the process of implementing the third party reimbursement system.

Contracting for both billing and services provides districts with staff that meet credential requirements and with agencies that have experience in the health care system. Contracted agencies are routinely responsible for documentation procedures and training as well as for the billing and reimbursement system. Medicaid and HCFA certified agencies have established quality-assurance standards.

Districts will need to resolve certain issues when contracting for both services and billing. These include integration of "non-staff" employees into the education system, dealing with salary differences between staff, the coordination of differences in intervention models, and supervision and control regarding the provision of services.

There are a substantial number of parameters that districts need to consider when contracting for billing and/or services. Districts should insist that they maintain ultimate control of the billing and/or service process. This is important as districts fulfill their obligation to provide a "free and appropriate" public education and outline the special education services that are to be part of a student's IEP. Federal law maintains that the school district is responsible for services outlined on the student's IEP, and the district should thus retain that responsibility.

When districts maintain control of the third party reimbursement system, they are able to establish processes for assuring families that lifetime benefits will not be depleted and for ensuring that the relationships districts establish with families for up to 21 years are not jeopardized. The district maintains responsibility in all liability issues. District control of the system will set the parameters for personal contacts and system implementation by billing agents and agencies with families. A cooperative effort by school districts and agencies will best meet the needs of students, the districts and the agencies.

When districts develop contracts with agents or agencies, the following parameters should be considered. First, education entities should insist on a cancellation clause that allows either party to terminate the contract with a 30- to 90-day notice. Districts should be wary of entering into long-term contracts without adequate cancellation clauses. Since accessing reimbursement for special education related services is new to both the district and the billing agent, both sources will need to seek additional knowledge regarding the issues and the system. The option to cancel should be clearly stated to cover circumstances in which the contract is not beneficial to both parties.

Second, districts are urged to negotiate charges for billing on a fixed cost per invoice basis rather than as a percentage of billing fees or reimbursement received. It is illegal in some states to charge a percentage of the fees collected or billed to Medicaid. Districts maintain more control if a fixed fee per invoice is paid and charges for services provided by the billing agent are itemized by type of service provided. Some agents charge for each invoice prepared, for data entry and for account service fees for each patient.

Even in states that allow agents to charge for fees collected through Medicaid, districts are cautioned against developing contracts with agents who charge a percentage of billed rather than collected amounts. The production of an invoice and submission of a claim do not guarantee any reimbursement. Being charged on the basis of gross billings could obligate a district to substantial fees without collection on any claims.

Billing agents and agencies may also charge districts for computers and terminals used to establish and operate the third party reimbursement system. Districts need to review the agency cost versus district implementation costs when reviewing system options. There are billing agents who charge a monthly terminal access fee rather than requiring purchase of a complex computer system and software. Fees based on monthly terminal usage that do not require substantial financial commitment by the district are preferable to purchase of a system from a billing agent.

School districts need to review their individual circumstances and available resources as they consider their options for implementation of a third party billing system. Whatever system the district chooses, educational entities must keep foremost in their mind that they are ultimately responsible and accountable for the services provided and the reimbursement collected.

Districts should be aware that they do not have to initiate a third party reimbursement system with all students with handicaps. Districts may choose to develop "pilot" projects for selected sites, targeted populations or individual types of service.

After districts delineate the issues and establish their objectives they can develop strategies and plan for implementation. They should be cautioned not to become bogged down at the issues or at the data-gathering phases. Since answers to many of the issues have not been formulated to date by any authoritarian or legal source, the data- and information-gathering process can continue forever. There comes a point when districts must move beyond issues and information and implement their system with strategic review of the process at specified time intervals.

Appendix 4-A

Related Services Survey

Provider of Services: _____

Time Period of Survey: _____

STUDENT NAME	Medical Diagnosis (if avail.)	MON	TUES	WED	THURS	FRI	SAT	Time Total		
								I	G	EV

Key: Individ.: I
Group: G
Eval: EV

Time periods should be indicated in minutes of service.

Appendix 4-B

Survey Format/Credential Requirements

Professionals	Number Personnel	Full-Time Equivalent (FTE)
Speech-Language Pathologist		
MA/MS & CCC		
MA/MS Completing CFY		
MA/MS Only		
BA		
Audiologist		
MA/MS & CCC		
MA/MS Completing CFY		
MA/MS Only		
Registered Physical Therapist		
Physical Therapist Assistant		
Registered Occupational Therapist		
Certified Occupational Therapy Assistant		
Licensed Consulting Psychologist		
Licensed Psychologist		
Psychiatrist		
Licensed as School Psychologist ONLY		
Nurse:		
LPN		
RN		
School Nurse		

KEY:
- FTE = Full-time equivalent
- MA = Master of arts
- MS = Master of science
- CCC = Certificate of clinical competence
- CFY = Clinical fellowship year
- BA = Bachelor of arts
- LPN = Licensed practical nurse
- RN = Registered nurse

Health Related Terminology

The medical and health care industry has developed specific language, terminology and definitions that relate to services provided by health care professionals and to the third party payment mechanisms for reimbursement. It is necessary to understand and use these terms to access third party payors. This chapter will provide definitions for terminology that school districts will need to use to access third party reimbursement.

Providers of special education health related services will also need to be familiar with the appropriate diagnostic and procedures codes for completing claim forms. The diagnostic codes (ICD-9) and procedures codes (HCPCS) provided later in this chapter are not all inclusive. The diagnostic codes are a random sample; the procedure codes represent those most often used by school district providers. Sources for obtaining complete sets of both types of codes are provided.

BILLING AND REIMBURSEMENT TERMINOLOGY

Assignment of Benefits An agreement between the patient and the provider that authorizes the carrier to pay benefits directly to the provider.

Beneficiary A person eligible to receive benefits under a health care plan.

Blue Cross and Blue Shield Associations The nonprofit tax-exempt organizations that provide payment for hospital and physician services. The national coordinating corporations of Blue Cross and Blue Shield merged on July 1, 1982, creating a single board of directors for the hospital and medical coverage plans. Traditionally, Blue Cross reimbursed for hospital benefits, and Blue Shield reimbursed for medical benefits provided by physicians.

Capitation A payment to a participating provider made on a per capita basis (for the number of subscribers served) rather than on the amount of services provided (fee for service). Capitated rate systems are normally associated with HMOs.

Carrier The insurance company, Health Maintenance Organization (HMO) and/or Preferred Provider Organization (PPO) that writes, underwrites and/or administers the health insurance policy, or HMO or PPO plan.

CHAMPUS (The Civilian Health and Medical Program of the Uniformed Services) A federally funded comprehensive health benefits program designed to provide eligible enrolled beneficiaries a supplement to medical care provided in military and public health service facilities. (CHAMPUS reimburses on a fee-for-service basis to providers not connected to military base services.)

Claim A written demand to the carrier, either by the insured or at his or her direction, for payment of benefits under a policy.

Claim Form The form used to present claim information and billing details to the carrier. There are several standardized forms available, including the HCFA 1500 and UB82.

Claim Processor An employee of the carrier who is responsible for processing claims as they are received from patients and providers.

Closed Panel Staff model HMOs are often referred to as "closed panel" HMOs because services may be obtained only from health professionals employed by the HMO.

Coinsurance The provision by a plan under which the beneficiary shares in the cost of specified covered expenses on a percentage basis (usually 20 percent). Coinsurance may also be referred to as copayment.

Comprehensive Medical Insurance A policy that provides both basic and major medical health insurance protection.

Consultant (Professional and/or Medical) An employee or contracted professional of the carrier who completes claims reviews for a specific medical discipline, such as a physician, nurse or therapist.

Contingency Reserve The funds withheld from provider reimbursement by the health plan for distribution to the provider at the end of the year based upon overall plan performance and provider-specific utilization data.

Coordination of Benefits (COB) The provision within a plan that establishes the fact that when a patient is covered by more than one carrier or plan, benefits paid by all plans are limited to 100 percent of the actual charges. Carriers coordinate benefits and determine primary and secondary responsibility based on state law.

Copayment The insured pays a specified amount per unit of service. The copayment does not vary with the cost of service.

Cost Sharing This method divides payments for services between the beneficiary and the provider. Coinsurance, copayments and deductibles are all forms of cost sharing.

Covered Services Those medical, hospital and other health care services provided to patients for which coverage is provided under the terms of the patient's policy.

CPT-4 (Current Procedural Terminology) A system of procedure codes developed and approved by the American Medical Association (fourth revision).

Crossover Patient A patient insured by both Medicare and Medicaid.

Deductible A specific dollar amount outlined in the beneficiary's plan that must be paid toward the cost of medical treatment before the benefits of the plan become effective.

Deductible Carryover A procedure under which covered charges incurred within the last three months of the year may be carried over and counted toward the next year's deductible.

Dependents The spouse, children and other dependent family members of the insured as defined by individual policy.

Disability Income Insurance A type of health insurance that provides periodic payment, in replacement of income, when an insured is disabled due to illness, injury or disease.

Durable Medical Equipment Equipment such as a wheelchair or a prone stander that is used repeatedly and is generally only useful to assist in the case of accident, illness or injury.

Electronic Claim A claim that is processed and delivered from one computer to another through a form of magnetic media (magnetic tape or diskette) or telecommunications (telephone link).

Exclusions Services, conditions or products that are specifically listed in a policy as not covered, thereby precluding reimbursement.

Explanation of Benefits (E.O.B.) A printed form included with payment from the carrier that details the benefits paid or charges rejected, or both.

E-Z Claim A three-part form that provides patients with a charge/receipt form and an instant insurance claim for submission to their carrier.

Fee For Service Payment by a payor to health care providers of a specific amount for each specific service given.

Gatekeeper Commonly used to refer to the physician group of physicians or HMO prior authorization personnel in prepaid health care arrangements who perform initial medical exams or screen prospective care prior to referral to other specialists or allied health professionals within or outside of the plan.

Health Care Financing Administration (HCFA) The federal government agency responsible for the administration of the Medicare and Medicaid programs under the auspices of the Department of Health and Human Services.

Health Care Financing Administration Common Procedure Coding System (HCPCS) HCPCS includes three levels of standardized procedure codes. HCPCS Level 1 codes are Current Procedure Terminology (CPT) codes, which are numeric. HCPCS Level 2 codes are national (assigned by HCFA) alpha-numeric (A-V plus a four-digit number) codes for procedures not included in CPT codes. HCPCS Level 3 codes are local (state) alpha-numeric (W-Z plus a four-digit number) developed to meet local procedure coding needs.

Health Maintenance Organization (HMO) An alternate delivery system that provides comprehensive health care services and emphasizes preventative and primary health care to reduce health costs. Enrollees pay a fixed payment for health services provided by a specified set of providers. There are four basic HMO models:

a. *Staff Model* Physicians are employed directly by the HMO.

b. *Medical Group* The HMO contracts with a separate medical group entity, and the medical group is compensated for each individual enrolled by the HMO and seen by the clinic.

c. *Individual Practice Association (IPA)* The HMO purchases services from physicians who are independent contractors rather than employees of or partners in the group. Within the IPA model, the physicians continue to practice within their own offices, thus providing for an expanded number of HMO delivery sites.

d. *Network HMO* Two or more group practices are provided a contract by the HMO to provide health care services.

ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) A coding manual developed by the National Center for Health Statistics and others to standardize disease and procedure classification throughout the United States. The codes are an adaptation of those generated by the World Health Organization and are widely accepted within health care billing.

Indemnity Protection against loss. The benefits paid in money to the insured by the insurer in a predetermined amount when specific services have been received by the insured.

Individual Practice Association (IPA) A physician organization that coordinates health care delivery to the members of the HMO. The IPA is an open panel group. Each physician within the IPA functions as an individual contractor, providing services within his or her own office, and is paid by the IPA on a fee-for-service basis.

Insured The person who is the primary policy holder in relation to the insurance program.

Intermediary An insurance carrier or data processing company that processes Medicare or Medicaid claims on behalf of the government.

Long-Term Disability Income Insurance A policy that pays benefits to a disabled person for as long as the person is disabled, within policy limitations.

Major Medical Insurance Health insurance policy that provides for reimbursement for major illness and injury to insured. Major medical policies normally include a substantial deductible followed by large benefit maximums.

Maximum Allowable Actual Charge (MAAC) The method for regulating fees that a non-participating provider may charge Medicare patients.

Maximums The upper dollar limit or amount a carrier will reimburse for specific benefit or policy during a specified period of time.

Medicaid A government-sponsored medical assistance program that enables eligible recipients to obtain medical benefits outlined within the state Medicaid guidelines.

Medicare A federal health insurance program for persons 65 and older, the disabled and those with chronic renal disorders.

Modifiers Codes used to supplement CPT and/or HCPCS codes to indicate that a service has been changed or modified in some manner.

Non-Participating Provider (Non Par) A provider who has **not** both signed a contract with a carrier (HMO or PPO) and agreed to provide services under the terms of the carrier and/or specific plan.

Participating Provider A provider who has signed a contract and agreed to provide services under the terms of the carrier and/or the specific plan.

Peer Review Organization The utilization and quality control review unit that reviews the validity of diagnostic information: the completeness, adequacy and quality of care provided; the appropriateness of admissions and discharges; and the appropriateness of services provided. Many professional associations have established quality of care and peer review organizations, standards and committees who complete the review process.

Plan of Care A written plan that details the patient's condition and functional level, treatment goals and objectives, the physician's order and/or certification, plans for continuing care, modifications to the plan and plans for discharge, when appropriate.

Precertification or Prior Authorization The process of obtaining permission to provide services **prior** to the provision of those services from the carrier (HMO or PPO), which will then reimburse the provider.

Predetermination The process of obtaining an estimate of the reimbursable amount the carrier will provide **prior** to providing services.

Preexisting Condition An injury, disease or handicapping condition that afflicted the insured prior to issuance of the insurance policy. Many health insurers commonly exclude preexisting conditions from coverage, although some will provide coverage after a specific period of time.

Preferred Provider Organization (PPO) A PPO is similar to an HMO that uses the open panel plan of preferred providers. Individual health care practitioners become preferred providers and are paid on a negotiated fee-for-service basis by a purchaser group. The patient routinely participates in the health care plan of a commercial carrier, which monitors utilization of service.

Primary Carrier The insurance carrier, HMO or PPO that has first responsibility for payment under coordination of benefit rules.

Progress Note A dated, written notation in the patient's chart detailing an encounter with the patient and the patient's response to that encounter for purposes of historical comparison.

Provider The person, professional or group practice recognized by the carrier who provides services to the patient.

Provider Agreement A contract between the provider and carrier that sets forth conditions of participation and reimbursement.

Quality Assurance Program Activities that measure the kind and degree of excellence of health care delivered. Quality of care is measured against preestablished standards. There are federal and state guidelines that relate to quality assurance programs within HMOs.

Reasonable Charge The amount Medicare will reimburse for a covered service. This is routinely the lowest of the actual, customary and prevailing charge.

Release of Information The patient's signature on a consent form that allows the release of information necessary to the settlement of the claim.

Schedule of Allowances A list of reimbursements allowed by the carrier for services provided.

Secondary Carrier The insurance carrier that is second in responsibility within the coordination of benefits.

Subscriber A term often used synonymously with either member or beneficiary. The term routinely relates only to the individual who has elected to contract for or participates in the health insurance or HMO plan for himself or herself and eligible dependents.

Third Party Payor Any organization, public or private, that reimburses or insures health and medical expenses on behalf of beneficiaries or recipients. The individual generally pays a premium for such coverage in all private and some public programs. The person receiving the service is the first party; the provider or supplier is referred to as the second party; and the organization paying for the service is the third party.

Usual, Customary and Reasonable (UCR) A method of determining prevailing reimbursement by comparing the provider's charges to those of his or her peers within the same community and discipline.

Workers' Compensation A program mandated by state law that provides coverage of medical expenses for employees who have been injured during the course of their employment.

PROCEDURE CODES

The procedure code is one of the most important entities to be entered on the insurance claim form. Since it is necessary for the insurance carrier to understand exactly what service or procedure was provided, this code must reflect that service or procedure exactly. The procedure coding scheme is a very precise process requiring considerable knowledge of medical terminology and clinical procedures. The therapeutic specialist and the student's physician are the professionals with the best ability to judge the service provided. It should therefore be the responsibility of the service provider to enter on the billing form the procedure code that best reflects the student's services.

Procedure codes have been minimally defined by various professionals. Professional associations have attempted to further define the scope of practice as it relates to a procedure code. School districts should contact their state professional associations for further information regarding procedure code definitions.

Historically, there has been a multitude of coding systems variable by payor source and area of the United States. In 1983, Medicare created a new coding system: HCPCS—Health Care

Financing Administration Common Procedure Coding Scheme. As noted earlier, there are three levels of standardized procedure codes within the HCPCS system. Level 1 is made up of Current Procedure Terminology (CPT-4) codes, which are all numeric. Level 2 includes alpha-numeric codes that are determined at the national level. Level 3 is composed of alpha-numeric codes that are determined at the state level. HCPCS are updated and revised annually.

HCPCS Level 1: CPT Codes

CPT-4 is the fourth revision of a numeric listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and medical providers. CPT codes are updated annually by the American Medical Association. Books listing the codes may be purchased from a local technical book store or from the American Medical Association, P.O. Box 10946, Chicago, Illinois 60610-0946 (Telephone: (800) 621-8335). The approximate cost of the book for non-members of the AMA is $33.

HCPCS Level 2: National Codes

HCPCS Level 2 codes are alpha-numeric codes, consisting of letters from A through V, followed by four numbers. These codes are established at the national level. A listing of all national codes is available free from the U.S. Government Printing Office, Washington, D.C. 20402.

HCPCS LEVEL 3: Local Codes

HCPCS Level 3 local codes are alpha-numeric codes beginning with letters W through Z, followed by four numbers. These codes are established by a committee of local Medicare intermediary, Medicaid and major carrier representatives. A listing of all local codes is available from each state's Medicaid agency.

HCPCS Code Priorities

There is overlap between the three coding levels and in some instances the service provider must determine which code is the most appropriate. The Level 1 codes are always primary, followed by local codes (Level 3) and then national codes (Level 2). When the CPT code contains the word "specify," the author suggests that a Level 2 or 3 HCPCS code be substituted, whenever possible.

It is unnecessary to provide the written description on the claim form when the numeric code is provided. In fact, if both are given and the description provided is different from the procedure referenced by number, it may cause the carrier to reject the claim or to request additional information.

Most third party payors, including Medicaid, require the use of HCPCS coding. In some states, however, Medicaid restricts the codes that can be used for services provided in the schools. Providers of health related special education services should contact their state Medicaid agency to determine the specific codes required by their agency.

In the section following an explanation of the process required to establish code fees (which comes next) is a sample listing of procedure codes representing all three HCPCS levels. Complete descriptions of the numeric CPT codes (Level 1) can be found in a CPT-4 manual.

The sample HCPCS Level 3 codes listed beginning with the letter X are local codes currently used in Minnesota. Many other states currently use the same Level 3 (X) codes.

ESTABLISHING PROCEDURE CODE CHARGES

School districts will need to establish fees for each procedure code. Providers of health care routinely calculate Usual and Customary (U & C) charges based on the costs of providing services. School districts need to consider the following parameters when determining fees for related services:

- Equipment costs and depreciation
- Consumable supply costs
- Indirect department costs
  The costs associated indirectly with the services, (such as typing, office supplies, billing forms, scheduling, and so forth)
- Personnel costs
  Include direct treatment time and preparation time for staff providing services
- Administrative costs
- Profit margin

Insurance carriers and HMOs routinely reimburse providers on a standardized U & C fee-per-procedure code, which they have calculated based on the standard fees submitted by providers within the same grouping and geographic area. Some carriers reimburse for the fee submitted by the provider if the fee is lower than the customary fee. School districts may wish to survey their local health care providers to obtain data regarding community standards when developing fee schedules.

PHYSICAL THERAPY CPT PROCEDURE CODES

Physical therapy CPT procedure codes are found in the Physical Medicine section of the CPT code book. The procedure codes range from 97010 through 97799.

PHYSICAL THERAPY HCPCS LEVEL III PROCEDURE CODES

NO.	DESCRIPTION
X4521	Physical therapy, group session
X4600	Physical therapy evaluation/re-evaluation treatment planning

OCCUPATIONAL THERAPY HCPCS LEVEL III PROCEDURE CODES

NO.	DESCRIPTION *(Alphabetic Order)*
X4511	Occupational therapeutic services (specify)
X4522	Occupational therapy, cognitive skills, each 15 minute segment
X4510	Occupational therapy, evaluation/re-evaluation
X4520	Occupational therapy, group session
X4513	Occupational therapy, group social interactive and psychological intrapersonal skills, each 15 minute segment, per person
X4515	Occupational therapy, motor skillls, each 15 minute segment
X4524	Occupational therapy, preventive skills, each 15 minute segment
X4517	Occupational therapy, sensory integrative skills, each 15 minute segment
X4512	Occupational therapy, social interaction and psychological intrapersonal skills, each 15 minute segment
X4526	Occupational therapy therapeutic adaptions, each 15 minute segment

	(Numeric Order)
X4510	Occupational therapy, evaluation/re-evaluation
X4511	Occupational therapeutic services (specify)
X4512	Occupational therapy, social interaction and psychological intrapersonal skills, each 15 minute segment
X4513	Occupational therapy, group social interaction and psychological intrapersonal skills, each 15 minute segment, per person
X4515	Occupational therapy, motor skills, each 15 minute segment
X4517	Occupational therapy, sensory integrative skills, each 15 minute segment
X4520	Occupational therapy, group session
X4522	Occupational therapy, cognitive skills, each 15 minute segment
X4524	Occupational therapy, preventive skills, each 15 minute segment
X4526	Occupational therapy therapeutic adaptions, each 15 minute segment

SPEECH-LANGUAGE PATHOLOGY CPT PROCEDURE CODES

NO.	DESCRIPTION
92506	Medical evaluation, speech, language and/or hearing problems
92507	Speech, language or hearing therapy, with continuing medical supervision; individual
92508	Group

SPEECH-LANGUAGE PATHOLOGY HCPCS LEVEL II & III PROCEDURE CODES

NO.	DESCRIPTION
X4610	Speech therapeutic services, by speech therapist
X4611	Consultation, basic
X4612	Consultation, extended
X4613	Programmed Independent Practice
X4614	Consruction/Programming/Adaptation of augmentative communication devices, materials outside of therapy session, each 15 min. segment
V5301	Basic assessment of specific single speech, voice, language cognitive/ communication or oral pharyngeal (e.g., dysphagia) disorder (excudes screening)
V5310	Comprehensive assessment of speech, voice, language systems, oral/ pharyngeal sensorimotor competencies and/or communication abilities of a hearing impaired individual (aural rehabilitation assessment) (excludes screening)
V5321	Assessment for oral or laryngeal prosthesis or artificial larynx (excludes V5010 hearing aid assessment)
V5322	Assessment for augmentative communicative system or device (excludes V5010 hearing aid assessment)
V5330	Treatment for speech, language, oral/pharyngeal and/or communication disorder, per session
V5335	Repair/Modification of oral or laryngeal prosthesis or artificial larynx
V5336	Repair/Modification of Augmentative communicative system or device (excludes adaptive hearing aid)
V5360	Unlisted speech-language service (specify)
V5362	Speech screening
V5363	Language screening
V5364	Dysphagia screening

AUDIOLOGY CPT PROCEDURE CODES

Audiology CPT procedure codes are found under Special Otorhinolaryngologic Services: Audiologic Function Tests with Medical Diagnostic Evaluation in the CPT code book. The procedure codes range from 92551 through 92599.

AUDIOLOGY HCPCS LEVEL II & III PROCEDURE CODES

NO.	DESCRIPTION
V5000	Base audiologic assessment — hearing assessment including the measuring of hearing acuity and test relating to air conduction, bone conduction, reception threshold, speech discrimination, and acoustic immitance tests (excludes hearing aid assessment)
V5001	Comprehensive audiologic assessment — hearing assessment including a basic audiologic assessment and assessment of vestibular and/or audiologic function by specialized electrophysiologic and/or behavioral tests
V5002	Assessment of vestibular and/or audiologic function by specialized electrophysiologic test(s), e.g., auditory evoked potentials, electronystagmography, electrocochleography
V5003	Assessment of vestibular and/or audiologic function by specialized behavioral test(s), e.g., specialized speech tests and tests for non-organic hearing etiology
V5008	Hearing screening
V5010	Assessment for hearing aid
V5011	Fitting/Orientation/Checking of hearing aid
V5012	Complete cochlear implant rehabilitation including adjusting and testing of equipment and auditory training
V5014	Repair/Modification of a hearing aid
V5016	Unlisted audiologic procedure (specify)
X4611	Consultation, basic
X4612	Consultation, extended

PSYCHIATRY CPT PROCEDURE CODES

Psychiatry CPT procedure codes are found in the Psychiatry section of the CPT code book. The procedure codes range from 90801 through 90915.

HCPCS LEVEL III PROCEDURE CODES

INDEPENDENT LICENSED PSYCHOLOGIST

X0630	Psychological testing by a licensed psychologist, per hour. Specify test(s)
X0640	Initial office or outpatient visit with evaluation and history, per session, by licensed psychologist
X0641	Follow-up office visit by licensed psychologist, per 15 minutes
X0645	Initial inpatient hospital visit including history and evaluation, per session, by licensed psychologist
X0646	Follow-up hospital visit by licensed psychologist, per 15 minutes
X0647	Consultation, initial, by licensed psychologist, one hour
X0648	Consultation, follow-up by licensed psychologist, per 15 minutes
X0650	Psychotherapy by licensed psychologist, one hour
X0651	Psychotherapy by licensed psychologist, one half hour
X0655	Psychotherapy, group (maximum 10 persons per group) by licensed psychologist, per session
X0656	Family members psychotherapy conjoint, two or more members, family group, evaluation and therapy per hour, by licensed psychologist
X0660	Biofeedback by licensed psychologist, one hour
X0661	Biofeedback by licensed psychologist, one half hour

SERVICES BY SOCIAL WORKER, ANALYST, OR COUNSELOR

X0680	Psychiatric service by social worker, specify
X0681	Psychiatric service by other analyst or counselor, specify

Providers of health related special education services need to use ICD-9 codes that relate to the services provided (for example, physical therapy or speech-language pathology), the provider of services and the student. Only the most appropriate and relevant diagnosis codes should be included on the claim form. The following examples provide instances of correct use of ICD-9 codes.

a. A child with a speech-language delay and unspecified motor problems has a history of chronic otitis media (ear infections). The correct ICD-9 code for the speech-language services provided is 381.1 (Chronic Serous Otitis Media), but this code would not be used for physical therapy intervention.
b. A child has a speech-language delay and a history of seizures. The correct ICD-9 code is 345.9 (Seizure Disorder) when providing speech-language services, occupational and/or physical therapy.
c. A developmentally delayed student has profound mental retardation. The correct ICD-9 code is 318.2 (Profound Mental Retardation). Note that in the ICD-9 codes there are different classifications relating to the severity of mental retardation.
d. A child exhibits developmental delays with athetoid cerebral palsy. The correct ICD-9 code is 333.7 (Athetoid Cerebral Palsy) when providing speech-language services or physical and occupational therapy.

Books that contain current and complete listings of ICD-9 CM codes are available at local technical book stores or from the American Medical Association, P.O. Box 10946, Chicago, Illinois 60610-0946 (Telephone (800) 621-8335). The approximate cost of the book to non-members (of the AMA) is $48. The ICD-9-CM is updated on a routine basis, and supplemental diagnosis codes are released between book revisions. The American Medical Association can provide districts with updates.

The following listing of ICD-9 codes represents sample codes that may be pertinent to schools in relation to the provision of physical and occupational therapy, speech-language pathology and audiology services.

ICD-9-CM CODES

ICD-9-CM is the International Classification of Diseases Codes, 9th Revision, Clinical Modification. Developed and maintained by the World Health Organization, ICD-9 codes are used to describe illnesses, injuries and accidents for the purposes of medical research and reporting. The ICD-9 system numerically classifies medical diagnosis by a code number, which districts need to use when processing claims.

Most insurance carriers, HMOs and Medicaid agencies require the use of ICD-9 codes on the billing format. There is adequate space for listing up to four codes on the standard HCFA 1500 claim form. When providers fail to provide an ICD-9 code, when the code is inconsistent with the service or procedure, when the code does not substantiate the need for the level of service provided and/or when multiple diagnosis codes that confuse the claims examiner are provided, there are problems with payors. Confusion on the part of the payor can be avoided by including the ICD-9 code on each claim and limiting the codes used to those most pertinent and most clearly **medically related** to the services provided. A child receiving physical therapy, for example, with a diagnosis of cerebral palsy and chronic otitis media would not have the chronic otitis media ICD-9 code listed on the claim for physical therapy; the otitis media is not pertinent to the physical therapy services the child receives because of his or her cerebral palsy.

SAMPLE ICD-9 CODES
(alphabetical listing)

NO.	DESCRIPTION
794.02	Abnormal EEG
796.1	Abnormal reflex
786.09	Apnea (newborn)
388.11	Acoustic trauma
784.3	Acquired aphasia
436.	Acute but ill-defined, cerebrovascular disease
742.2	Agenis of corpus collosum
750.11	Aglossia
315.01	Alexia
784.61	Alexia and dyslexia
740.0	Anencephalus
756.0	Anomalies of skull and face bones
750.10	Anomaly of tongue, unspecified
348.1	Anoxic brain damage
784.41	Aphonia
333.7	Athetoid cerebral palsy
314.0	Attention deficit disorder
299.0	Autistic
212.1	Benign neoplasm of larynx
210	Benign neoplasm of lip, oral cavity, and pharynx
229	Benign neoplasm of other and unspecified sites
369.00	Blind, congenital or acquired
950.9	Blind due to injury
770.7	Bronchial pulminary dysplasia (infant & newborn)
941	Burn of face, head, and neck
579.0	Celiac's disease
434.1	Cerebral embolism
851.	Cerebral laceration and contusion
434.0	Cerebral thrombosis
437.9	Cerebrovascular disease
476.0	Chronic laryngitis
381.1	Chronic serous otitis media
749.1	Cleft lip
749.10	Cleft lip, unspecified
749.0	Cleft palate
749	Cleft palate and cleft lip
749.00	Cleft palate unspecified
749.2	Cleft palate with cleft lip
749.20	Cleft palate with cleft lip, unspecified
850.	Concussion
389.0	Conductive hearing loss
750.12	Congenital adhesions
771.1	Congenital cytomegalovirus infection

NO.	DESCRIPTION
742.3	Congenital hydrocephalis
920.	Contusion of face, scalp, and neck except eye(s)
315.4	Coordination disorder
771.1	Cytomegolovirus - congenital
389.7	Deaf mutism
388.00	Degenerative and vascular disorders of the ear
715.90	Degenerative joint disease
294.1	Dementia in conditions classified elsewhere
524	Dentofacial anomalies, including malocclussion
783.24	Developmental delay of milestones
315.02	Developmental dyslexia
315.31	Developmental language disorder
343.0	Diplegia
520	Disorder of tooth development and eruption
388.5	Disorders of acoustic nerve
758.0	Down syndrome
779.5	Drug withdrawal syndrome in newborn
784.5	Dysphasia, dysarthria, slurred speech and other disorders
763.1	Dystocia (newborn)
478.6	Edema of larynx
309.83	Elected mutism
7420	Encephalocele
767.6	Erb's palsy
783.4	Failure to thrive
783.3	Feeding problems in infant or adult
779.3	Feeding problems in newborn
760.71	Fetal alcohol syndrome
750.13	Fissure of tongue
802.20	Fracture of face bone, mandible
802.	Fracture of face bones
807.5	Fracture of larynx and trachea, closed
807.6	Fracture of larynx and trachea, open
310.0	Frontal lobe syndrome
530.1	Gastroesophageal reflux
V44.1	Gastrostomy
780.	General symptoms N0S *(not otherwise classified)*
780	General unspecified symptoms (N0S) classified
365.9	Glaucoma
343.1	Hemiplegic
320.0	Hemophilus meningitis
333.4	Huntington's chorea
769	Hyaline membrane disease
331.4	Hydrocephalic
244.9	Hypothyroidism
779.8	Hypotonia
781.3	Hypotonia GM delay

NO.	DESCRIPTION
388.43	Impairment of auditory discrimination
953.4	Injury to brachial plexus
343.	Infantile cerebral palsy
345.6	Infantile spasms
854.	Intracranial injury of other and unspecified nature
431.	Intrecerebral hemorrhage
907.0	Late effect of intracranial injury w/o mention of skull
438.	Late effects of cerebrovascular disease
326.	Late effects of intracranial abscess or pyogenic infection
307.9	Lisping
750.15	Macroglossia
383.	Mastoiditis and related conditions
386.0	Meniere's disease
322.9	Meningitis
742.1	Microcephalus
317.	Mild mental retardation
389.2	Mixed
315.5	Mixed development disorder
318.0	Moderate mental retardation
759.7	Multiple congenital anomalies
340.	Multiple sclerosis
332.2	Myoclonic seizure
237.7	Neurofibromatosis
388.1	Noise effects on inner ear
388.10	Noise effects on the inner ear, unspecified
388.12	Noise induced hearing loss
381.	Nonsupportive otitis media and eustachian tube disorders
388.32	Objective tinnitus
388.4	Other abnormal auditory perception
744.02	Other anomalies of external ear with impairment of hearing
750.1	Other anomalies of tongue
742.	Other congenital anomalies of nervous system
478.5	Other diseases of vocal cords
388	Other disorders of the ear
389.8	Other forms of hearing loss
368.44	Other localized visual field defect
742.4	Other specified anomalies of brain
744.8	Other specified anomalies of face and neck
750.26	Other specified anomalies of the mouth
759.8	Other specified anomalies: syndromes
315.8	Other specified delays in development
315.2	Other specific learning difficulties
784.6	Other symbolic dysfunction
344.8	Other unspecified paralytic syndrome
387.0	Otosclerosis
478.3	Paralysis of vocal cords or larynx

NO.	DESCRIPTION
332.0	Parkinson's disease, paralysis agitans
478.4	Polyp of vocal cord or larynx
765.1	Preterm infant
318.2	Profound mental retardation
315.00	Reading disorder, unspecified
593.9	Renal failure
769	Respiratory distress syndrome
345.9	Seizure disorder
780.3	Seizure disorder general
389.1	Sensorineural
381.04	Serous otitis media
318.1	Severe mental retardation
343.2	Spastic athetoid cerebral palsy
343.9	Spastic cerebral palsy congenital infantile
315.1	Specific arithmetic disorder
315	Specific delays in development (non-neurological)
315.0	Specific reading disorder
741.9	Spina bifida
334.9	Spinal cerebellar degen
759.6	Sturge-Weber syndrome
307.0	Stuttering and stammering
388.31	Subjective tinnitus
388.2	Sudden hearing loss, unspecified
388.3	Tinnitus
388.30	Tinnitus, unspecified
750.0	Tongue tie
519.0	Tracheostomy complication
388.02	Transient ischemic deafness
758.6	Turners disease
315.9	Unspecified delays in development
728.9	Unspecified disorder of muscle, ligament and fascial
389.9	Unspecified hearing loss (deafness N0S)
319.	Unspecified mental retardation
310.9	Unspecified nonpsychotic mental disorder
730.2	Unspecified osteomyelitis
386.9	Unspecified vertiginous syndromes and labyrintine disorders
369.65	Vision impairment: one eye normal, one eye no vision
368.40	Visual field defect, unspecified
368.4	Visual field defects
784.4	Voice disturbance
784.40	Voice disturbance, unspecified
335.0	Wernig-Hoffman disease

INSURANCE CLAIM FORMS

For years so many different formats were used to file insurance claims that the American Medical Association recognized the need to standardize and simplify both claims and reporting forms for physicians. This simplification process produced the Uniform Health Insurance Claim Form, known as the HCFA 1500, or Standard Claim Form. The HCFA 1500 is currently accepted by the majority of insurance carriers and HMOs in the United States and some Medicaid plans. The standard exception is for institutional billing to Medicare by organizations Medicare has classified as institutions (such as rehabilitation agencies and long-term care facilities, for example).

School districts are encouraged to use the accepted Standard Claim Forms. These forms are available from the American Medical Association in single form, snap out form and continuous forms for use with computer. Information regarding cost can be obtained by contacting the AMA at (800) 621-8335.

School districts may decide to contract with a billing agent who chooses to use a computer-generated format of the Standard Claim Form often referred to as a "superbill" or to complete purely "electronic claims." Electronic claims provide the billing data from the place of service directly to the insurer's computer system, using a telephone modem. Electronic claims provide a paperless system of claims. Regardless of which standardized format is used by the district, however, it is important to note that claims are paid more frequently and in a more timely manner when standard forms are utilized.

HCFA 1500 Requirements

The HCFA 1500 Claim Form is separated into two sections. The first section (I) contains information about the patient and the insured. The second section (II) contains information regarding the service provider. Not all sections need to be completed by the school district provider.

The following comments represent information gathered from the author's experience about the best procedures to follow in completing these forms to ensure acceptance of claims by major insurance and HMO plans. (Refer to appendix 5-A containing the Sample HCFA 1500 Form to follow the commentary easily.)

Section I

1. Patient's Name — It is important to enter the full name of the patient, including complete last name, first name and middle initial. The form requires a precise order.
2. Date of Birth — Enter the patient's date of birth in a month, day and year format.
3. Insured's Name — Enter the complete name of the insured. If the insured is the same as the patient, complete with "same."
4. Patient's Address — Enter the patient's complete address. It is important to enter all pertinent data and correct zip code.
5. Patient's Sex — Check the appropriate male or female box.

6. Insured's Identification Number — Enter the insured's primary identification number, including any letters. This number is found on the insured's insurance identification card. Routinely, the number contains the insured's or subscriber's Social Security number, with modifications.

7. Patient's Relationship to the Insured — Enter an X in the appropriate box.

8. Insured's Group Number — Enter the "group number" or "group name" found on the insurance identification card.

9. Other Health Insurance Coverage — If the patient is covered by additional insurance plans, enter the name, address and any available policy numbers of these plans in this section.

10. Condition Related to Employment or Accident — Put an X in the appropriate box or boxes if treatment is related to a work related injury or an accident related injury. Work related injury claims are filed with "Workers' Compensation" and accident related claims may be filed with an automobile insurance carrier or an attorney.

11. Insured's Address — Enter the insured's complete street address unless it is the same as the patient's and then enter "same."

12. Release of Information — It is imperative that the patient or guardian sign a release of information prior to billing the insurance carrier. The release allows the service provider to share information with the insurance carrier that is necessary to process claims. The patient/insured may sign either the claim form or a standard release. If a standard release is signed, it is necessary to note on the claim form that a release is "on file." "Signature on file" can be typed into this space when the provider has a written release: that will be accepted by most carriers.

13. Assignment of Benefits — The signature of the insured is required to allow the carrier to pay benefits directly to the provider and thus it is wise for the provider to maintain a written "assignment of benefits" on file from each of its insureds. Carriers will generally accept "Signature on file" in this space and pay directly to the provider.

Section II

14. Date of Illness or Injury — Enter the date of the onset of the illness or injury, if available.

15. Date First Consulted — Enter the date the patient first consulted the provider for this condition, if available. **It is wise to leave this area blank.**

16. Date of Same or Similar Illness — **It is wise to leave this area blank.**

17. Date Patient Able To Return to Work — Complete **only if** the patient is being seen for work related injury or disability.

18. Date of Total Disability — Complete **only if** the patient is being seen for work related injury or disability.

19. Referring Physician — Enter the name of the referring physician.

20. Hospitalization Dates — Enter dates of admission and discharge **only if** services are rendered in hospital or subsequent to a hospital visit. **School districts should leave this section blank.**

21. Facility Name and Address — Enter the name and address of the clinic or hospital **only if** services were rendered at a site other than the provider's office or patient's home. The school district site of service is considered the provider's office.

22. Outside Laboratory Work — Put an X in the "yes" box if laboratory charges are contracted. Put an X in the "no" box if laboratory work is performed in your own laboratory. **School districts should leave this blank.**

23. Diagnosis — Enter the ICD-9-CM number(s) related to the services provided. One or more codes may be listed, with the primary code first. One individual code per service may be entered in Section 24-D in place of codes in Section 23.

23B Check the box for "yes," if the services provided were part of an EPSDT. When billing an HMO enter the prior authorization number, which corresponds to the dates of services provided.

24. Date(s) and Place(s) of Service

Column A — Date of Service — Enter the month, day, and year that relate to the service or procedure provided. When like services are provided and "from — to" dates are used, the number of services that pertain to the procedure in Column C should appear in Column F.

Column B — Place of Service — Enter the place of service code, using the codes listed on the back of the claim form. Services provided within the provider's office are coded 3.

Column C — Procedure Code and Description — Enter the appropriate Level 1, 2 or 3, HCPCS procedure code.

Description — Enter the precise description that reflects the HCPCS code entered in Column C **or leave blank**.

Column D — Diagnosis Code — Enter the appropriate diagnosis code using ICD-9-CM or enter the number of the code it relates to, from Column 23.

Column E — Charges — Enter the charges for the procedures provided.

Column F — Days or Units — Enter the number of units in relation to the day or dates of service and procedure code.

Column G — Type of Service — **Leave blank.**

Column H — **Leave blank.**

25. Signature of Provider — The provider or an authorized representative must sign the provider's name and the date. Most carriers accept a signature stamp or computer-generated signature.

26. Accept Assignment — The provider indicates by marking an X in the appropriate box whether or not it will accept assignment from Medicare. Assignment from Medicare requires the provider to accept the payment from Medicare as total payment for services rendered, with no additional charges for the patient. **Leave blank.**

27. Total Charges — Enter the total of all the charges itemized in Section 24, Column E.

28. Amount Paid — **Leave blank.**

29. Balance Due — Enter the TOTAL CHARGES amount from Box 27.

30. Provider's Social Security Number — Enter the provider's Social Security number unless billing for a group practice. Then enter the Federal Tax ID.

31. Provider Information — Enter the provider name, complete address, telephone number and provider number. This is the name and address of the school district.

32. Patient Account Number — Enter the provider account number for this patient, if available.

33. Employer Identification Number — Enter the identification number of the group practice, if available.

FORM APPROVED
OMB NO. 0938-0008

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

☐ MEDICARE (MEDICARE NO.) ☐ MEDICAID (MEDICAID NO.) ☐ CHAMPUS (SPONSOR'S SS#) ☐ CHAMPVA (VA FILE NO.) ☐ FECA BLACK LUNG (SS#) ☐ OTHER (CERTIFICATE SS#)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
2. PATIENT'S DATE OF BIRTH
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) TELEPHONE NO.
5. PATIENT'S SEX — MALE ☐ FEMALE ☐
6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)
7. PATIENT'S RELATIONSHIP TO INSURED — SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.) — ☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)
10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT — YES ☐ NO ☐; B. ACCIDENT — AUTO ☐ OTHER ☐
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE) TELEPHONE NO.
11a. CHAMPUS SPONSOR'S STATUS — ☐ ACTIVE DUTY ☐ DECEASED ☐ RETIRED; BRANCH OF SERVICE
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING): I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW. SIGNED DATE
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW. SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES
16a. IF EMERGENCY CHECK HERE ☐
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY — FROM — THROUGH
DATES OF PARTIAL DISABILITY — FROM — THROUGH
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (eg. PUBLIC HEALTH AGENCY)
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES — ADMITTED — DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ ☐ NO CHARGES
23. A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR ICDA CODE
EPSDT YES ☐ ☐ NO
FAMILY PLANNING YES ☐ ☐ NO
PRIOR AUTHORIZATION NO.

24. A DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G. TOS	H. LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES) OR CREDENTIALS. I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF. DATE
25. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ ☐ NO
27. TOTAL CHARGE $
28. AMOUNT PAID $
29. BALANCE DUE $
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S, SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.
32. YOUR PATIENT'S ACCOUNT NO.
33. YOUR EMPLOYER I.D. NO. I.D. NO.

34. PLACE OF SERVICE (TOS) CODES ON THE BACK REMARKS

FMS 08172 12 PKX C 2 WKC

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (C-2) (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

BEST COPY AVAILABLE

6

Medicaid, EPSDT and Other Federally Funded Third Party Reimbursement Sources

MEDICAID

Medicaid is a federal and state funded health care program established in 1965 under Title XIX of the Social Security Act. Although it is most often identified as a separate entity, Medicaid is considered a third party payor.

Medicaid is the federally established term for the Medical Assistance program, but some states use the term Medicaid, others use Medical Assistance, and California uses the unique term, "MediCal." Only one state, Arizona, has no Medicaid program, but it has established a special managed care system.

The Medicaid program is administered at the state level and benefits are paid by a match of state and federal dollars. The federal match ranges from 50 percent to 80 percent, variable by state. (The federal dollar match by state is identified in chapter 3 of this publication.) The percentage of federal dollar match is determined by a federally established formula and based on state per capita income.

The titles of the agencies administering state Medicaid programs vary by state. Currently they include the Department of Human Services, the Department of Public Welfare and the Department of Income Maintenance. Each state's administering agency and its title are identified in the Medicaid Agency contacts listing in appendix 6-A.

The benefits provided by the state Medicaid programs also vary. Federal law mandates that each state provide a core group of services, including physician services, laboratory and x-ray services, in-patient hospital care, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Optional services include dental care, case management, physical and occupational therapy and speech-language pathology and audiology services.

Each state files a "state plan" outlining the mandated and optional services its state Medicaid program will provide. Because Medicaid is an open-ended entitlement program, all persons who meet the state's eligibility requirements as outlined in their state plan must be provided with those services, regardless of the cost. Each state is required to pay for a

percentage of its program's cost; the way each state controls those costs is to limit eligibility and services in their state plan. The Medicaid state plan is available on request to the consuming public through each state Medicaid office.

The federal laws that regulate Medicaid and provide guidelines for implementation of the Medicaid program are complex and are continually changing. This chapter provides basic information in regard to Medicaid eligibility and benefits. School districts will need to contact their state Medicaid program for state plan specifics and details regarding coverage for optional services. Related services provided by a school district (such as physical and occupational therapy, speech-language pathology and audiology, and psychological services) are considered optional by federal Medicaid standards. One federally mandated program does provide reimbursement for these related services, however, and that is the EPSDT option. The use of the EPSDT option to fund IEP related services is discussed in the EPSDT section.

All providers rendering services to Medicaid recipients must be formally enrolled as Medicaid providers. Federal regulation mandates that Medicaid have a signed agreement with each person or institution it authorizes as a provider.[1] The procedures for enrolling as a Medicaid provider vary by state. School districts must contact their local Medicaid office for their state-specific requirements.

The billing procedures for each state Medicaid program also vary. Some states insist upon the use of the HCFA 1500 form with specific completion requirements. Other states have developed their own billing invoice and accept claims only on that invoice. Most states accept standard HCPCS for submission of procedure codes, although there are a few states that still use a "home grown" coding system. The national trend is certainly to use the standardized HCPCS coding format.

Once a provider is enrolled within the state's Medicaid program, the state issues it a provider manual, which contains state legislation and rules that pertain to the provision of services in that state. The provider manual also covers documentation parameters and billing specifics. Most Medicaid offices employ provider training specialists to help new providers learn the Medicaid requirements.

The reimbursement rates established for services provided to Medicaid recipients vary by state and by the type of services provided. Rates are routinely established by legislative authority within each state. Medicaid reimbursement does not parallel the usual and customary charges of individual providers. In fact, reimbursement rates are routinely set at levels substantially lower than providers charge. The rates per procedure code, as established by each individual Medicaid program, are public and are available upon request.

Medicaid is only one source of third party reimbursement. As part of their initial planning process, districts must contact their local Medicaid office and request the appropriate procedure codes for their type of provider and the corresponding reimbursement rates. If the rate of reimbursement available will not cover the district's cost of services, this information may be a determining factor in the decision on whether to initiate a third party reimburse-

[1] 42 C.F.R. Part 431.107.

ment system. Districts also need to consider the number of students who are eligible for Medicaid benefits. If the number of Medicaid eligible students and corresponding reimbursements are low, districts may choose to access only other third party sources.

Persons of low income may be eligible for Medicaid in three ways: as categorically needy, as medically needy and under the amendments of 1986, the Omnibus Budget Reconciliation Act (sometimes referred to as SOBRA). There are many other optional variations states can choose to extend Medicaid coverage to specific groups of persons, however. Some of the optional methods for extending Medicaid benefits include Waiver Services and the TEFRA 134 Option. Details regarding these optional benefits are included in this chapter.

Categorically Needy

Persons are considered as categorically needy when they receive assistance under the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) programs. Eligibility is linked to the federally established poverty level. States are federally mandated to provide Medicaid benefits to those persons identified as categorically needy, but each individual state determines the standards for eligibility for each program.

Medically Needy

Each state has the option of providing Medicaid benefits to other persons whose income, while low, is above the state's established AFDC standard. Each state Medicaid plan outlines the level and criteria the state has selected for qualifying as medically needy. The state may also allow other low income persons who have extraordinary medical expenses to qualify for Medicaid when medical expenses consume a high portion of their income.

SOBRA Amendments

In April 1987, each state was given the option of extending Medicaid to all pregnant women and their children (up to age five) who have income levels below state-specified dollar amounts down to the federally determined poverty level. These amendments allow states to provide Medicaid or categorical need standards.

WAIVER PROGRAMS

The Omnibus Budget Reconciliation Act (OBRA) of 1981, Section 2176, created Waiver programs.[2] The concept of a Waiver program was created to allow recipients who would normally require an institutional level of care and are Medicaid recipients (hospital, nursing home or institution, for example) to live within the community. Each state has the option of amending their state Medicaid plans to designate both the population they choose to target and the services they wish to provide through their Waiver program.

The design of Waiver programs varies dramatically from state to state, as do the optional benefits provided by state Medicaid programs. For example, Minnesota currently has two Waiver programs that affect children: The Community Alternative Care Waiver and the

[2] P.L. 97-35, 95 Stat. 357.

Home and Community Based Waiver for Persons with Mental Retardation. Within both those programs the child is "deemed" to stand alone in terms of income and asset tests for determining eligibility for Medicaid benefits. In other words, the income of the child's parents and/or guardians does not count when determining eligibility. These Waiver participants are provided all the benefits of standard Medicaid in Minnesota, and afforded the availability of such services as case management, respite care, homemaker services, foster care and habilitation. The benefits provided through these Waiver programs vary.

Iowa, on the other hand, has established a model Waiver program that provides Waiver benefits to the child/disabled and mentally retarded/developmentally delayed target populations. There, Waiver participants are provided with such services as homemaker and home health aid services, personal care attendants, adult day care and respite care. If the client is eligible for standard Medicaid benefits, however, he or she cannot access the Waiver program.

The target population the Medicaid program chooses to service and the range of benefits provided is determined by each individual state Medicaid program. Because of the vast differences among states, school districts need to contact their state Medicaid office for details regarding their state's Waiver programs.

A report produced by the National Governors' Association, "Medicaid Home Care Options for Disabled Children," indicates the following populations have been targeted by Waiver programs throughout 48 states: aged/disabled, AIDS/AIDS related complex, child/disabled, mentally ill, mentally retarded/developmentally disabled.[3] The services provided may include case management, homemaker, home health aid, personal care attendants, adult day care, habilitation services, respite care, transportation and modifications to the home. As of September 1989, 28 states had a total of 42 home- and community-based Waiver programs in effect, and 20 states had a total of 24 home- and community-based model Waiver programs established.

Children's Home Care Option (TEFRA-134)

The Children's Home Care Option is often referred to as the TEFRA-134 option because of the acronym for the law that established it — Tax Equity and Fiscal Responsibility Act. This program became a Medicaid option in 1982,[4] and the number of children enrolling under its terms in Medicaid is steadily increasing: As of September 1989, 17 states were serving 3,776 children. Those states providing the TEFRA option include Arkansas, Delaware, Georgia, Idaho, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, Rhode Island, South Dakota, Vermont, West Virginia and Wisconsin.

Defining disability as "the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12

[3] Linda Hall, "Medicaid Home Care Options for Disabled Children," Washington, DC: National Governors' Association, 1990.

[4] P.L. 97-248, 96 Stat. 324, Section 134, 42 U.S.C. 1396a (e)(3) (1982).

months," the Children's Home Care Option allows a "disabled" child who requires an institutional level of care (hospital, nursing home or intermediate care facility) to live at home and be enrolled as a Medicaid recipient without including the income and assets of the child's parents.

Under this program the disabled child is "deemed" to stand alone in terms of income and asset considerations for eligibility for Medicaid benefits. (The concept of "deeming" is the same as outlined in Waiver services.) Allowing the child to stand alone in terms of assets means that the financial status of the child's family is not considered. The cost of services for a child eligible for benefits through this Children's Home Care Option cannot exceed the average per capita expenditure for institutional care, but this option is a new source of financing for health care services for children with severe handicaps through age 18.

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

The EPSDT option is a federally mandated component of the Medicaid program that must be part of each state plan. The EPSDT program as enacted in 1967 was designed "to discover, as early as possible, the ills that handicap our children" and to provide "continuing follow up and treatment so that handicaps do not go neglected."[5] All children from birth to age 21 who are eligible for Medicaid are also eligible for Title XIX EPSDT services. Any medical or remedial care service outlined in the Medicaid statute, even when the service is not available to other Medicaid recipients within the state, can be provided through the EPSDT program.

The Omnibus Reconciliation Act of 1989 significantly expanded the eligibility and benefits of EPSDT. Those changes to EPSDT make this Medicaid program a crucial source of funding for IEP related services, especially in states where therapeutic and rehabilitative services are not Medicaid funded.

The original intent of EPSDT was to enable Medicaid-eligible children to receive screenings, well-child supervision visits and necessary treatment services. The scope of services provided and the providers who could offer EPSDT benefits were originally limited by individual Medicaid state plans. Many state Medicaid plans did not cover all the federally outlined diagnostic and treatment services allowed and severely limited the providers who could enroll with Medicaid and provide EPSDT services.

In November 1989, Congress expanded the scope of the EPSDT program in the Omnibus Budget Reconciliation Act (OBRA). The changes in the program, which took effect April 1, 1990, have had a dramatic impact for the coverage of IEP related services. The number of children who qualify as Medicaid recipients has been significantly expanded because OBRA has raised the income standards for eligibility to 133 percent of the federally established poverty level. Additionally, the changes now provide Medicaid-eligible children the opportunity for individualized services to detect and treat medical, dental, mental health, developmental, vision and hearing problems. Furthermore, states cannot impose limits unrelated to medical necessity on the amount, frequency or duration of diagnostic or

[5] *CDF Reports*, April 1990, pages 1-2.

treatment services. States must now establish periodic exam schedules to meet reasonable standards of practice for medical, vision, dental and hearing services. And, if a child needs services prior to the outlined periodic exam schedule, the child is entitled to all services identified, and the state Medicaid program must reimburse for those services. States cannot restrict the type of EPSDT provider to a public health clinic or a specific type of private practitioner. Any health care provider eligible for a Medicaid provider status, who is certified to practice in that state, can be reimbursed for the EPSDT services provided.

EPSDT Diagnostic and Treatment Services

A medical screening must minimally include: (1) a comprehensive health and developmental history in both the physical and mental health areas, (2) a comprehensive unclothed physical exam, (3) any immunizations required for age and the child's health history, (4) all laboratory tests (including lead blood tests and urinalysis, for example) and (5) health education for both parents and the child.

A vision screen must cover diagnosis and treatment for any vision defects, including eyeglasses. A dental screen must provide maintenance of dental health, restoration of teeth, relief from pain and treatment of infections. A hearing screen must provide diagnosis and treatment for any hearing defects and must include hearing aids.

When a condition is detected during the EPSDT screening, the Medicaid-eligible child is entitled to the following health services, which are reimbursable under Section 1905(a) of Title XIX.[6]

Chiropractor
Christian Science Providers
Clinic Services
Diagnostic Services
Emergency Hospital Services
Eyeglasses
Family Planning
Hospice Services
ICF for Mentally Retarded
Inpatient Psychiatric Services
Laboratory Clinic Services
Nurse Midwife Services
Occupational Therapy
Optometrist
Other Practitioner Services
Outpatient Hospital Services
Personal Care Services
Physical Therapy
Physician
Podiatrist
Prescribed Drugs
Preventive Services
Private Duty Nursing
Prosthetic Devices
Rehabilitation
Rural Health Clinic Services
Skilled Nursing and Home Health Services
Speech-Language-Hearing Services
Transportation

The 1989 OBRA changes took away the individual state's ability to control limits and periodic screens for the EPSDT program. State Medicaid programs may not require prior authorization of periodic and interperiodic screening services provided through the EPSDT option, but they may require prior authorization for treatment services. State Medicaid

[6] See P.L. 101-239, Section 6403 amending 42 U.S.C. 1396(a).

EPSDT programs cannot apply limits, however, to the amount, duration and scope of services that meet the state Medicaid definition of "medically necessary" for treatment of a condition detected during an EPSDT screening.

EPSDT Providers

Prior to the EPSDT program changes in 1989, some state Medicaid programs limited EPSDT providers to those qualified to furnish a full screening package, which included medical, developmental, hearing and vision exams. These rules significantly limited the number and type of providers. The new amendments allow a provider to furnish only a portion of the total EPSDT assessment and still be enrolled as an EPSDT provider. Each state Medicaid program retains the authority to establish standards for the quality of services and credential requirements, but states cannot establish arbitrary provider qualifications. Any provider who meets the state Medicaid plan requirements can provide partial and full screening and treatment services.

State Medicaid programs may contract with an HMO to provide EPSDT benefits. However, the contracted HMO provider must provide all EPSDT benefits, either by contract or through employees.

School districts are encouraged to seek provider status through the EPSDT option within Medicaid if other provider options are unavailable. Most IEP related services can be provided and reimbursed through the program. The EPSDT option provides school districts the ability to offer preventative, medical, dental and rehabilitative services to all Medicaid-eligible children from birth to age 21. School districts can utilize the EPSDT option as part of the child-find and diagnosis components of early intervention programs. The EPSDT option provides Medicaid funding for IEP related services for children when reimbursement for those services may not be available through the state's standard Medicaid benefits.

Most states employ staff (who may be referred to as the EPSDT coordinator) whose duties are to manage the EPSDT option. Each state is actually entitled to additional federal funds to defray costs of this personnel. School districts should contact their state EPSDT coordinator for enrollment specifics and application forms.

The Children's Defense Fund (CDF) provided strong support for the changes to the EPSDT program that were enacted in 1989.[7] The CDF is currently making staff available to state Medicaid programs to provide information and consultation services in an attempt to secure all the benefits Congress outlined as quickly as possible. Some state Medicaid EPSDT plans will require significant changes. The Secretary of Health and Human Services is required to establish annual state EPSDT participation goals, and states must file annual reports indicating compliance data for the goals established. School districts should contact the CDF if they encounter difficulty with their state in establishing provider status or obtaining reimbursement for EPSDT services provided.

[7] The CDF is located at 122 C Street, NW, 4th Floor Washington, DC, 20001, (202) 628-8787.

SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Another federally funded program that provides reimbursement and services for health care is Services for Children with Special Health Care Needs (SCH). This program was previously entitled Crippled Children's Services; however, some states—and the federal government—now call the program Services to Children with Special Health Care Needs. A few states still use the title Crippled Children's Service.

The program is funded at the federal level through Title V of the Social Security Act Maternal and Child Health Block grants and exists in some form in every state. A number of states and individual counties provide other funds to the SCH program, and some coordinate EPSDT and other services through the SCH program.

The coverage for services provided within each state under this program varies as do the criteria for accessing funds or services. Some SCH programs provide services through SCH centers and others provide reimbursement to participating providers for specified services at contracted facilities. The SCH program is managed by different governmental agencies within different states, including the Department of Health, the Department of Human Services and the Department of Education.

School districts should contact their state office for SCH for provider enrollment and student benefit information. The state contacts for SCH can be found in chapter 7 of this publication in the list of major health insurance carriers.

Appendix 6-A

STATE MEDICAID AGENCIES

ALABAMA

Ms. Carol A. Herrmann
Commissioner
Alabama Medicaid Agency
2500 Fairlane Drive
Montgomery, AL 36110 (205) 277-2710

ALASKA

Ms. Kim Busch
Director
Division of Medical Assistance
Department of Health & Social Services
P.O. Box H-07
Juneau, AK 99811-0660 (907) 465-3355

AMERICAN SAMOA

Mr. Charles R. McCuddin
Deputy Director for Planning & Development
Medicaid Coordinator
LBJ Tropical Medical Center
Pago Pago, AS 96799 011-684-633-4559

ARIZONIA

Leonard J. Kirschner, M.D., MPH
Director
Arizona Health Care Cost Containment System (AHCCCS)
801 East Jefferson
Phoenix, AZ 85034 (602) 234-3655 X4053

ARKANSAS

Mr. Ray Hanley
Assistant Deputy Director
Office of Medical Services
Arkansas Department of Human Services
P.O. Box 1437, Slot 1100
Little Rock, AR 72203-1437 (501) 682-8292

CALIFORNIA

Mr. John Rodriquez
Deputy Director
Medical Care Services
Department of Health Services
714 P Street, Room 1253
Sacramento, CA 95814 (916) 322-5824

COLORADO

Mr. Gary Toerber
Director
Bureau of Medical Services
Department of Social Services
1575 Sherman - 6th Floor
Denver, CO 80203-1714 (303) 866-5901

CONNECTICUT

Ms. Linda Schofield
Director
Medical Care Administration
Department of Income Maintenance
110 Bartholomew Avenue
Hartford, CT 06106 (203) 566-2934

DELAWARE

Ms. Ruth S. Fischer
Medicaid Director
Department of Health & Social Services
Delaware State Hospital
New Castle, DE 19720 (302) 421-6139

DISTRICT OF COLUMBIA

Ms. Lee Partridge
Chief
Office of Health Care Financing
D.C. Department of Human Services
2100 Martin Luther King, Jr. Ave., SE, Suite 302
Washington, DC 20023 (202) 727-0735

FLORIDA

Mr. Gary J. Clarke
Assistant Secretary for Medicaid
Department of Health & Rehabilitation Services
1317 Winewood Boulevard
Building 6, Room 233
Tallahassee, FL 32399-0700 (904) 488-3560

GEORGIA

Mr. Aaron J. Johnson
Commissioner
Georgia Department of Medical Asst.
2 Martin Luther King, Jr. Dr., SE
1220-C West Tower
Atlanta, GA 30334 (404) 656-4479

GUAM

Ms. Mary Medina
Acting Administrator
Bureau of Health Care Financing
Department of Public Health & Social Services
P.O. Box 2816
Agana, GU 96910 011-671-734-7269

HAWAII

Mr. Winifred Odo
Administrator
Health Care Administration Division
Department of Human Services
P.O. Box 339
Honolulu, HI 96809 (808) 548-3855

IDAHO

Mrs. Jean Schoonover
Chief
Bureau of Medical Assistance
Department of Health & Welfare
450 West State Street
Statehouse Mail
2nd Floor
Boise, ID 83720 (208) 334-5794

ILLINOIS

Mr. Tim Claborn
Administrator
Division of Medical Programs
Illinois Department of Public Aid
201 South Grand Avenue, East
Springfield, IL 62743-0001 (217) 782-2570

INDIANA

Gary Kyzr-Sheeley, Ph.D.
Director
Medicaid Division
Indiana State Department of Public Welfare
100 North Senate Avenue
State Office Bldg., Room 701
Indianapolis, IN 46204 (317) 232-6865

IOWA

Mr. Donald Herman
Division Administrator for Medical Services Division
Department of Human Services
Hoover State Office Bldg., 5th Floor
Des Moines, IA 50319 (515) 281-8794

KANSAS

L. Kathryn Klassen, R.N., M.S.
Director
Medical Programs
Department of Social and Rehabilitation Services
Docking State Office Building
Room 628-S
Topeka, KS 66612 (913) 296-3981

KENTUCKY

Mr. Roy Butler
Commissioner
Department of Medicaid Services
3rd Floor
275 East Main Street
Frankfort, KY 40621 (502) 564-4321

LOUISIANA

Carolyn O. Maggio, Ph.D.
Director
Bureau of Health Services Financing
P.O. Box 91030
Baton Rouge, LA 70821-9030 (504) 342-3891

MAINE

Ms. Elaine Fuller
Director
Bureau of Medical Services
Department of Human Services
State House Station 11
Augusta, ME 04333 (207) 289-2674

MARYLAND

Mr. Nelson Sabatini
Deputy Secretary
Health Care Policy, Finance and Regulation
Department of Health & Mental Hygiene
201 West Preston Street, Room 200
Baltimore, MD 21201 (301) 225-6535

MASSACHUSETTS

Mr. Bruce M. Bullen
Associate Commissioner for Medical Services
Department of Public Welfare
180 Tremont Street, 13th Floor
Boston, MA 02111 (617) 574-0205

MICHIGAN

Mr. Kevin Seitz
Director
Medical Services Adminis.
Department of Social Services
P.O. Box 30037
Lansing, MI 48909 (517) 335-5001

MINNESOTA

Mr. Robert Baird
Director
Health Care Programs Division
Department of Human Services
444 Lafayette Road, 6th Floor
St. Paul, MN 55155-3848 (612) 296-2766

MISSISSIPPI

Mr. James C. Lowery
Director
Division of Medicaid
Office of the Governor
801 Robert E. Lee Building
239 North Lamar Street
Jackson, MS 39201-1311 (601) 359-6050

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Ms. Donna Checkett
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Division of Medical Services
Department of Social Services
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Jefferson City, MO 65102 (314) 751-6922

MONTANA

Ms. Nancy Ellery
Administrator
Medicaid Services Division
Department of Social & Rehabilitative Services
P.O. Box 4210
Helena, MT 59604 (406) 444-4540

NEBRASKA

Mr. Robert Seiffert
Administrator
Medical Services Division
Department of Social Services
5th Floor
301 Centennial Mall South
Lincoln, NE 68509 (402) 471-9330

NEVADA

Ms. April Hess
Deputy Administrator
Nevada Medicaid Welfare Division
Department of Human Resources
2527 North Carson St.
Carson City, NV 89710 (702) 687-4378

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Mr. Philip Soule, Sr.
Administrator
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New Hampshire Division of Human Services
Department of Health & Human Services
6 Hazen Drive
Concord, NH 03301-6521 (603) 271-4353

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Mr. Saul M. Kilstein
Director
Division of Medical Assistance & Health Services
Department of Human Services
CN-712, 7 Quakerbridge Plaza
Trenton, NJ 08625 (609) 588-2600

NEW MEXICO

Mr. Bruce Weydemeyer
Director
Medical Assistance Division
Human Services Department
P.O. Box 2348
Santa Fe, NM 87504-2348 (505) 827-4315

NEW YORK

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Deputy Commissioner
Division of Medical Assistance
New York State Department of Social Services
40 North Pearl Street
Albany, NY 12243 (518) 474-9132

NORTH CAROLINA

Ms. Barbara Matula
Director
Division of Medical Assistance
Department of Human Resources
1985 Umstead Drive
Raleigh, NC 27603 (919) 733-2060

NORTH DAKOTA

Mr. Richard Myatt, Director
Medical Services
North Dakota Department of Human Services
600 East Boulevard
Bismarck, ND 58505-0261 (701) 224-2321

NORTHERN MARIANA ISLANDS

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Department of Public Health & Environmental Services
Commonwealth of the Northern Mariana Islands
P.O. Box 409 CK
Saipan, MP 96950 011-670-234-8950 X2905

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30 East Broad Street - 31st Floor
Columbus, OH 43266-0423 (614) 466-3196

OKLAHOMA

Mr. Charles Brodt
Division Administrator
Division of Medical Services
Department of Human Services
P.O. Box 25352
Oklahoma City, OK 73125 (405) 557-2539

OREGON

Ms. Jean I. Thorne
Director
Office of Medical Assistance
Department of Human Resources
203 Public Service Building
Salem, OR 97310 (503) 378-2263

PENNSYLVANIA

Mr. Gerald F. Radke
Deputy Secretary for Medical Assistance Programs
Department of Public Welfare, Room 515
Health & Welfare Building
Harrisburg, PA 17105-2675 (717) 787-1870

PUERTO RICO

Ms. Agneris Guzman
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Office of Economic Assistance to the Medically Indigent
Building A, G.P.O. Box 70184
San Juan, PR 00936 (809) 765-9941

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600 New London Avenue
Cranston, RI 02920 (401) 464-2121

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S.C. State Health and Human Services Finance Commission
P.O. Box 8206
Columbia, SC 29202-8206 (803) 253-6100

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Medical Services
Department of Social Services
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700 Governors Drive
Pierre, SD 57501-2291 (605) 773-3495

TENNESSEE

Mr. Manny Martins
Assistant Commissioner of Medicaid
Bureau of Medicaid
729 Church Street
Nashville, TN 37247-6501 (615) 741-0213

TEXAS

Donald Kelley, M.D.
Deputy Commissioner for Contracted Client Services
Department of Human Services
P.O. Box 149030
Austin, TX 78714-9030 (512) 450-3050

UTAH

Mr. Rod Betit
Director
Division of Health Care Financing
Utah Department of Health
P.O. Box 16580
Salt Lake City, UT 84116-0580 (801) 538-6151

VERMONT

Mr. Elmo A. Sassorossi
Director
Division of Medicaid
Department of Social Welfare
Vermont Agency of Human Services
103 South Main Street
Waterbury, VT 05676 (802) 241-2880

VIRGINIA

Mr. Bruce U. Kozlowski
Director
Virginia Dept. of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219 (804) 786-7933

VIRGIN ISLANDS

Ms. Myriam James
Director
Bureau of Health Insurance & Medical Assistance
Knud Hansen Complex
Charlotte Amalie
St. Thomas, VI 00802 (809) 774-4624

WASHINGTON

Mr. Ron Kero
Director
Division of Medical Assistance
Department of Social & Health Services
623 8th Avenue, SE
Mail Stop HB-41
Olympia, WA 98504 (206) 753-1777

WEST VIRGINIA

Ms. Helen Condry
Director
Division of Medical Care
West Virginia Department of Human Services
1900 Washington Street East
Charleston, WV 25305 (304) 348-8990

WISCONSIN

Ms. Christine Nye, Director
Bureau of Health Care Financing
Division of Helath
Wisconsin Department of Health & Social Services
P.O. Box 309
Madison, WI 53701-0309 (608) 266-2522

WYOMING

Mr. Kenneth C. Kamis
Director
Medical Assistance Services
Department of Health & Social Services
Hathaway Building, 4th Floor
Cheyenne, WY 82002-0710 (307) 777-7531

Private Insurance and Health Maintenance Organizations

INTRODUCTION

Currently, there are over 2,000 health insurance carriers in the United States and half as many Health Maintenance Organizations (HMOs). Many of these carriers have several types of plans available to meet the needs of the consumer. Some states, like Minnesota, California and Wisconsin, for example, have a large number of HMOs, which generally populate urban areas.

Just as it would be difficult for a health care administrator to become a special education director, the reverse is also true. Therefore, it is important for a school district to gather as much information as possible when developing a system to access third party reimbursement. Understanding the terminology associated with health care and the way in which the system works will help the district learn how to work within the health care arena and maximize reimbursement.

Information pertaining to third party coverage and specific policies must be obtained from the insured. A description of the statistical information school districts need to gather and sample formats to follow in doing so are found in chapter 8 (Documentation).

Consumers generally know very little about their health insurance and its policy's benefits and limitations until a medical need arises. They may understand the requirements of deductibles and coinsurance but rarely do they know if their policies contain lifetime caps, for instance, or limits on specific services. As the school district becomes an active participant in the third party reimbursement process, the need for knowledge regarding the differences among policies will become apparent.

One of the first steps a district must take in determining the availability of insurance benefits is to obtain a student's policy identification information. Most third party payors issue the insured an identification card, which provides the policy identification information necessary for claims processing. School districts are encouraged to periodically review identification cards for all students. Providers of clinical services (such as hospitals and physicians) routinely copy identification cards for inclusion in the patient record, and regularly recheck

this information, because it is not unusual for the insured to change plans or policies within any given school year. Most plan changes and open enrollment periods within various plans occur between October and January. Therefore, it is wise for the school district to request current plan information during a student's initial enrollment and again in January of each year. The district can simply request that the student's family complete a new health identification and information form in January of each year. Filing claims with a plan that no longer insures the student is time consuming and costly.

Policies and plan specifics can vary significantly by both carrier and employer specifications. Therefore, even students insured by the same carrier may have different plan policies and benefits. The school district's billing personnel can call the carrier with policy identification information and request coverage specifics, but not all insurers will provide the details. If the district identifies itself as a provider, however, and requests information about any policy limitations regarding the services being rendered by the district as a provider, carriers may provide the necessary information. Obtaining policy coverage limitations prior to initiation of services saves time and administrative costs.

Insurance carriers require different information than do HMO or PPO plans. Most standard indemnity carriers **do not** require prior authorization for evaluation or therapeutic services, but **do** require standard documentation procedures. It is not unusual for a carrier to request copies of documentation during a postpayment review process or to request written documentation of services provided prior to payment of a claim.

The following are standard documentation procedures which are accepted by most insurance carriers when services are provided by licensed, certified providers. Details regarding documentation requirements are noted in chapter 8.

1. Physician authorization/order
2. Documentation of the evaluation and results (report)
3. Daily documentation of the services provided
4. Progress documentation
5. Documentation of continued physician authorization
6. Documentation of discharge from treatment

THIRD PARTY PAYORS

Third party payors can be categorized as follows: Commercial, Blue Cross and Blue Shield, Medicare, CHAMPUS, Medicaid, Workers' Compensation, HMO or PPO organizations, Services for Children with Special Health Care Needs and Self-Insured Plans.

Commercial Carriers

Commercial carriers provide contracts to individuals and groups. Payment for services is made to the beneficiary or assigned provider, based on an indemnity table or schedule of benefits for the medical services. Assignment of benefits by the insured does not always guarantee direct payment to the provider. Some policies limit direct payment to the insured and disallow assignment of benefits. In these cases, the school district is responsible for tracking reimbursement and seeking payment from the insured.

Most plans follow one of the three basic types of benefit schedules.

a. *Basic*: The plan pays total costs up to a maximum dollar amount for almost all services, with only a few exclusions (such as cosmetic surgery and mental disorders). The plan may specify a deductible, and services may be provided in various settings including a hospital, home or office. The school district is considered an office setting for claims purposes.

b. *Major Medical*: A policy of this type is designed for catastrophic situations; reimbursement is not made for minor health problems. Major medical policies are normally associated with large deductibles and may have caps in maximum lifetime reimbursement.

c. *Comprehensive*: This type of policy combines basic and major medical policies.

Insurance companies are routinely referred to as "carriers." The insurance carrier may also be called an insurer, underwriter or administrative agent, but the term does not apply to HMOs. The insurance carrier provides coverage as outlined in the contract between the person purchasing the insurance (company or employer or individual) and the insured or contracting group.

Each insurance carrier offers many different plans. A single carrier may sell contracts to individuals and groups and may also act as an administrator for a separate entity. Even some government programs, such as Medicare, are administered by an insurance company (Blue Cross/Blue Shield or Travelers, for example). Furthermore, insurance carriers are often used as administrators for insurance benefits by companies who establish "self-insured plans" for their employees' health care benefits.

The list of carriers identified in this chapter represents the most frequently named and well-known carriers. The listing does not provide **all** insurance carriers in the United States. School districts should contact their local state Insurance Federation or their state insurance commission for a list of current carrier sources in their state.

Blue Cross and Blue Shield (BCBS)

Although originally separate entities, Blue Cross and Blue Shield have merged to provide comprehensive coverage for hospital and non-hospital services. BCBS is a not-for-profit corporation, not a commercial insurance company. A person becomes a member by entering into a contract with the local BCBS plan. The insured person becomes a subscriber, not a policy holder, and holds a certificate, not a policy under BCBS definitions and language. BCBS functions much as a commercial carrier does, except in its language definitions for contracts and subscribers: BCBS routinely requires providers to meet BCBS standards and enroll in order to become participating providers. The provider requirements for reimbursement by BCBS vary by plan and state. BCBS may also administer Medicare, Medicaid and CHAMPUS in some states.

Medicare

Medicare is the health insurance program governed by the Social Security Administration's Health Care Financing Administration (HCFA). It consists of two parts.

Medicare Part A: Covers hospital and skilled nursing services (when certain requirements are met) for most everyone over age 65, all those classified as permanently disabled and those with chronic renal disease. Medicare Part A coverage is automatic.

Medicare Part B: Covers physician services, laboratory tests and x-rays. Medicare Part B has an annual deductible and a 20 percent copay.

CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)

The CHAMPUS program provides health care benefits to dependents of active and retired military personnel and their families. CHAMPUS provides that these persons may seek medical care by civilian personnel and have the cost of care paid by the federal government.

Workers' Compensation

The Workers' Compensation plan provides medical coverage for expenses incurred for workers whose injuries or illness are the result of their employment. Workers' Compensation is framed and controlled by each state's Workers' Compensation office. Workers' Compensation claims require special information (date of injury, employer and so forth) and reimbursement may be fixed by procedure code. This varies by state. Some procedures may require prior authorization. It would be unusual for a student receiving IEP related services to have health benefits through a Workers' Compensation plan.

Medicaid

The Medicaid program provides medical coverage and health care assistance to the medically and categorically needy and is administered by both the federal and state governments. Each state establishes and operates its own program within the general federal guidelines. The range of services covered and reimbursements offered vary by state. Some states require prior authorization for all services and some reimburse for only a limited amount of service. Some state Medicaid programs require claims to be submitted on specific forms with specifically required information, while others accept the Standard Claim Form. Details regarding the Medicaid program and its benefits are found in chapter 6 of this publication.

Health Maintenance Organization (HMO)

HMOs provide medical coverage and health care benefits and services to enrolled members. Individuals and groups can enroll in an HMO plan. HMO services may be provided by a specific clinic or restricted provider or provider group. There are four types of HMOs. They include the staff model, the medical group, the individual practice association and the network HMO.

The purpose and function of an HMO are different from those of an insurance plan. Commercial carriers, BCBS, CHAMPUS, Medicare, Medicaid, Workers' Compensation, Services for Children with Special Health Care Needs and Self-Insured Plans are all organizations that pay benefits to an insured but do not provide medical services. An HMO, on the other hand, is a prepaid plan that offers an organized system of providing *and* paying for health care services. Routinely, the insured of an HMO does not pay the medical provider on a fee-for-services basis. Instead the premium paid by the patient or the patient's employer

covers all care outlined in the policy, and the patient does not incur deductibles and coinsurance costs. The provider is paid directly by the HMO. There are HMO plans, however, that require the patient to pay a fixed copay amount for specified care: $10 per physician visit, for example.

HMOs are popular prepaid health plans because the insured or the employer pays a fixed premium and the patient knows that additional medical costs will not be incurred. HMOs routinely provide or arrange for the provision of the following services: physician and hospital services; laboratory and x-ray procedures; mental health and therapeutic services; prenatal, postnatal and well-baby care; immunizations and routine health examinations; and prescription drugs with a copayment. Some HMOs also provide for long-term rehabilitative services, home health services, and eye and dental care.

HMOs reimburse providers by two methods: on a fee-for-service basis or a capitation rate. Under most circumstances independent providers and group practices contract with the HMO to provide a specific range of services. Under the first reimbursement scheme, the medical provider agrees to supply the services to the HMO's enrolled participants on a discounted fee-for-service basis. The provider may discount the usual and customary fee charge by as little as 5 percent or as much as 30 percent. The discount varies by contract.

The second HMO reimbursement scheme is based on a capitation rate. The HMO determines a fixed rate of payment (the capitation rate) for the HMO enrollee, based on age and other statistical variables, and pays the HMO enrollee's identified primary physician a fixed rate per month. Any additional care or services authorized by the primary physician must be paid for from the capitation rate previously determined. The capitation rate method is primarily used in the group practice model, and the system only remains profitable for the group practice when there are many healthy HMO enrollees to cover the cost of care for the enrollees in need of greater medical care.

HMOs limit the number of health care providers within their network. Limiting the provider network and controlling reimbursement are necessary in order to establish fixed premium costs. Most HMOs require providers to sign formal contracts with the HMO and become a "preferred provider" of the HMO's health care network. Some HMOs require the enrollee's primary physician to refer **only** to the HMO's enrolled provider network, but others reimburse for therapeutic intervention to non-participating providers.

To enter this system, school districts need to contact the HMOs serving their student population and become participating providers. All HMOs have representatives that can inform the district about provider specifications and requirements.

The majority of HMOs require prior authorization (otherwise known as precertification) for therapeutic and psychological services. This means that the HMO must grant permission for the provision of services prior to the initiation of intervention. Initial prior authorization is often obtained verbally by telephone, but some HMOs have established written procedures for obtaining such authorization. Many insurance carriers also require prior authorization for some services now, especially hospital admissions or second surgical opinions.

Basically, HMOs require the same documentation procedures as the insurance industry, plus the additional step of obtaining prior authorization. Thus, it is imperative that the prior authorization mechanism be documented by the district. Two formats for documenting the

prior authorization process are provided in Appendices 7-A and 7-B. The HMO may issue a prior authorization or certification number, which must be noted on the claim form when submitting the bill for services. Documentation of the HMO contacts and the type, frequency and duration of services authorized assists when collecting reimbursement. An HMO may even request copies of progress summaries and daily notes when treatment continues for more than 90 days.

The duration of therapeutic intervention an HMO will authorize also varies by HMO policy and plan specifics. Some HMOs will grant a limited number of therapeutic visits and others will authorize a specific time period. Most HMOs do not authorize more than 90 days of services without reauthorization. A school district may require the professional providing such services to obtain prior authorization or it may establish a system whereby documentation is provided to a billing specialist who then secures the HMOs authorization.

Regardless of who obtains the prior authorization, the term of that prior authorization must be documented. Prior to expiration of the original authorization period, new prior authorization must be obtained. It is to the benefit of the district in both time and administrative costs to seek prior authorization for long time periods, like 90 days. The authorization period represents calendar days, not treatment days. When an HMO authorizes treatment days, that is referred to as a specific number of treatment visits, and the term "days" is not used.

The number and type of HMOs are growing throughout the country. The benefits provided and the laws and regulations that govern HMOs differ by state. HMOs are not always regulated by the same agency as insurance companies in each state; they may instead be regulated by the Department of Health or the state's insurance commission. School districts should contact the appropriate agency in their state for both a current list of HMO sources and the mandated HMO regulations. A list of HMOs (by state) is provided in appendix 7-C, but this list does not represent all HMOs in the United States.

Preferred Provider Organization (PPO)

A PPO is similar in operations and benefits to an HMO that functions in an independent practice model. The PPO contracts with selected health care providers to treat enrolled patients for a negotiated fee. PPOs do not usually assume the risk that the HMO does for significant medical illness by the patients enrolled, however. The PPO patient is usually enrolled in the health care plan of a major carrier or a self-insured plan.

PPOs were developed as an alternative to the traditional fee-for-service system that requires the patient to assume deductibles and coinsurance and the HMO system that may contain many restrictions. The PPO allows the patient (1) to reduce the cost of care and expand benefits by obtaining health care services from the preferred providers or (2) to seek health care from non-participating providers at a higher cost. Each PPO develops its own standards and contracts to meet the needs of the patients and their employer or contracting group.

PPOs maintain a strong utilization review program and monitor participating provider's practice and referral patterns. Similar to an HMO, the PPO may require prior authorization for therapeutic intervention. The school district needs to determine the plan specifics when a PPO is identified as a student's health carrier. PPOs generally enforce strong utilization review programs and require patients to seek care through their established provider

network. PPOs will allow a school district to enroll as a preferred provider and then monitor the type, frequency, duration and outcome of services with close scrutiny.

Combined HMO and Commercial Carrier

Many HMOs now offer the benefits of an HMO in combination with the flexibility of indemnity insurance, as offered by commercial carriers. Under these plans, the HMO enrollee (1) receives all the health care benefits without paying any fees beyond premiums by obtaining all health care from the HMO's enrolled provider network or specified list of providers and (2) pays deductibles and coinsurance at a specified rate for all health care services obtained from non-participating providers and receives benefits similar to those of standard indemnity plans.

Services for Children with Special Health Care Needs (SCH)[1]

An SCH program is one usually regulated by the state's Department of Health, which provides reimbursement for medical evaluation, treatment and habilitation of children with chronic handicapping (or disabling) conditions. SCH provides prior authorization for most services. The SCH program is supported by state and federal funds and the scope of coverage for services varies by state. The legal guardian of a child must apply for the benefits of the program. The list of SCH offices that appears later in this chapter contains most state contacts for Services for Children with Special Health Care Needs.

Self-Insured Plans

Self-insured plans represent a form of health insurance under which the health care benefits are designed and dictated by the employer, who self-insures the health care program. Due to the rapidly increasing high cost of health care, this type of health insurance plan is growing because major corporations have found it less costly to provide their own health care plans and dictate the benefits.

The employer may hire a well-known indemnity carrier to administer the self-insured plan. Very often, the insured does not even realize that the plan is self-insured, rather than under a standard indemnity carrier. Self-insured health care plans may not be subject to the strict state laws that regulate the insurance industry. This is true, for example, in Minnesota. Employers often choose the self-insured plan to provide minimal benefit packages for less cost.

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[1] This program is sometimes titled Crippled Children Services.

Appendix 7-A

Prior Authorization Form

Carrier / HMO: _____

Prior Authorization: _____

Student Name: _____

Street Address: _____

City / State / Zip: _____

Telephone: _____ Date of Birth: _____

Subscriber's Name: _____

Street Address: _____

City / State / Zip: _____

Member No.: _____ Group No.: _____

Admitting Physician: _____

Terms of Authorization: _____

Diagnosis: _____

Treatment: _____

Representative Providing Authorization: _____

Prior Authorization / Certification No.: _____

Appendix 7-B

Re-Authorization Log

Student: _____ DOB: _____

School: _____ Discipline: _____

DATE	INS/HMO/ PERSON/CONTACTED	TYPE AND FREQUENCY OF TREATMENT	AUTHORIZATION PERIOD	CERTIFICATE/ AUTHORIZATION #

Appendix 7-C MAJOR HEALTH INSURANCE CARRIERS

A.A.R.P. HEALTH INSURANCE PLAN
P.O. Box 13999, Philadelphia, PA 19187 (800)523-5880

ADMIRAL LIFE INSURANCE CO. OF AMERICA
300 2nd Ave. South, Minneapolis, MN 55401 (612) 388-5479

AEGON REINSURANCE COMPANY OF AMERICA
127 John St., New York, NY 10038 (212) 248-1390

AETNA LIFE & CASUALTY
CORPORATE OFFICE
151 Farmington Ave., Hartford, CT 06156 (203) 273-0123
PRIVATE PLAN CLAIMS
CT P.O. Box 888, Hartford, CT 06101 (800) 243-8093
GROUP PLAN CLAIMS
AL 300 Riverchase Galleria (205) 985-3400
Birmingham, AL 35244 (800) 654-1649
CA P.O. Box 12340, Fresno, CA 93765 (209) 436-3100
P.O. Box 1900, Orange, CA 92668 (714) 542-2445
HUGHES CLAIMS
CA P.O. Box 11100, Santa Ana, CA 92668 (714) 542-2445
101 W Broadway, San Diego, CA 92101 (619) 231-4200
CT P.O. Box 800, Enfield, CT 06082 (203) 741-2581
DE P.O. Box 7012, Dover, DE 19903 (302) 674-7600
(800) 338-7807
GA P.O. Box 1058, Macon, GA 31298 (912) 749-1400
HI P.O. Box 1484, Honolulu, HI 96806 (808) 537-6154
IL 4501 N. Sterling Ave., Peoria, IL 61615 (309) 686-2130
NAVISTAR CLAIMS
IL P.O. Box 5367, Rockford, IL 61125 (815) 229-2200
P.O. Box 5048, Rockford, IL 61125 (815) 229-2200
IN P.O. Box 2295, Fort Wayne, IN 46801 (219) 427-6200
P.O. Box 40988, Indianapolis, IN 46240 (317) 254-5600
J.C. PENNY CLAIMS
IN P.O. Box 40945, Indianapolis, IN 46240 (317) 254-5600
(800) 428-6111
UNITED MINEWORKERS CLAIMS
KY P.O. Box 35890, Louisville, KY 40232 (502) 426-7130
(800) 225-3593
MA 187 Billerica Road
Chelmsford, MA 01824 (508) 256-8162
MI 400 Renaissance Center
Detroit, MI 48243 (313) 259-7300
P.O. Box 3000, Grand Rapids, MI 49501 (616) 942-4000
MN 100 N. 6th St., Minneapolis, MN 55402 (612) 340-5250
SPERRY CLAIMS
MN P.O. Box 2909 Loop Station (612) 343-3000
Minneapolis, MN 55402 (800) 222-5246
NC 3300 Battle Ground Avenue
Greensboro, NC 27410 (919) 288-0611
UT P.O. Box 30995
Salt Lake City, UT 84130 (800) 242-8276
OHIO RETIREMENT SYSTEM CLAIMS
OH P.O. Box 16516, Columbus, OH 43216 (614) 890-9200
AMERICAN ELECTRIC POWER CLAIMS
OH P.O. Box 18037, Columbus, OH 43216 (614) 890-9200
P.O. Box 18040, Columbus, OH 43216 (614) 890-9200
P.O. Box 937, Toledo, OH 43695 (419) 321-2400

AETNA LIFE & CASUALTY (continued)
OWENS-ILLINOIS CLAIMS
OH P.O. Box 937, Toledo, OH 43695 (419) 321-2400
OK P.O. Box 1900, Orange, CA 92668 (714) 542-2445
OR P.O. Box 112, Portland, OR 97207 (503) 221-5550
PA 3541 Winchester Road
Allentown, PA 18104 (215) 391-1700
P.O. Box 1738, Reading, PA 19603 (215) 371-6100
(800) 544-2985
TN 1355 Lindfield Rd., Memphis, TN 38119 (901) 682-0023
TX 4444 Executive, El Paso, TX 79902 (915) 542-1931
VA P.O. Box 25519, Richmond, VA 23260 (804) 756-3500
WI P.O. Box 26279, Milwaukee, WI 53226 (414) 256-2200

AETNA LIFE INSURANCE CO.
GOVERNMENT-WIDE INDEMNITY
CORPORATE OFFICE
1133 20th St. N.W., Washington, DC 20036 (202) 775-6900
GROUP PLAN CLAIMS
OR P.O. Box 112, Portland, OR 97207 (503) 221-5550
TX 4050 Rio Bravo St., El Paso, TX 79902 (915) 532-1111
(800) 225-9509
VA 2809 Emerywood, Richmond, VA 23229 (804) 756-3550
(800) 225-9509

AID ASSOCIATION FOR LUTHERANS
4321 N. Ballard Rd., Appleton, WI 54919 (414) 734-5721

ALL AMERICAN ASSURANCE COMPANY
7887 East Belleview Ave. (303) 779-1111
Englewood, CO 80111 (800) 525-7662

ALLEGHENY NATIONAL LIFE INSURANCE CO.
4808 N. 22nd St., Phoenix, AZ 85016 (602) 957-1650
(800) 433-8181

AMALGAMATED LIFE & HEALTH INSURANCE COMPANY
333 S. Ashland Ave., Chicago, IL 60607 (312) 738-6150

AMERICAN BANKERS INSURANCE COMPANY
P.O. Box 2502, Waco, TX 76702 (817) 756-5531

AMERICAN FAMILY LIFE ASSURANCE
Claims Department, Columbus, GA 31999 (404) 323-3431
(800) 622-2345

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
80 F Street N.W., Washington, DC 20001 (800) 424-4308

AMERICAN GENERAL GROUP INSURANCE CO.
CORPORATE OFFICE
P.O. Box 660238, Dallas, TX 75266 (214) 841-1000
GROUP PLAN CLAIMS
CA P.O. Box 873, Sacramento, CA 95804 (916) 649-9143
425 California Street
San Francisco, CA 94104 (415) 781-6416
1188 Franklin Street
San Francisco, CA 94109 (415) 928-4475
2401 E. Katella Ave.
Anaheim, CA 92806 (714)634-0588
FL 6363 N.W. 6th Way (305) 772-6666
Ft. Lauderdale, FL 33309 (800) 345-7498
P.O. Box 2568, Jacksonville, FL 32203 (904) 390-7000
(800) 888-5256
2114 Airport Blvd.
Pensacola, FL 32504 (904) 478-3726
4511 N. Himes Ave., Tampa, FL 33614 (813) 877-7443
GA 1100 Ashwood Parkway (404) 395-4743
Atlanta, GA 30338 (800) 652-9970
MD 3910 Keswick, Baltimore, MD 21211 (301) 338-9820
TN American General Center
Nashville, TN 37250 (615) 749-1947
TX P.O. Box 4435, Houston, TX 77210 (713) 630-0263

AMERICAN HARDWARE MUTUAL INSURANCE CO.
CORPORATE OFFICE
P.O. Box 435, Minneapolis, MN 55416 (612) 920-1400
GROUP PLAN CLAIMS
MN P.O. Box 435, Minneapolis, MN 55440 (612) 935-1400
ND P.O. Box 2524, Fargo, ND 58108 (701) 293-6822
OH P.O. Box 68, Dublin, OH 43017 (614) 889-1309
215 Stanford Pkwy., Findlay, OH 45840 (419) 423-3823
TX 12200 Northwest Freeway (713) 680-0224
Houston, TX 77092 (800) 537-7256

AMERICAN HOME ASSURANCE CO.
CORPORATE OFFICE
70 Pine St., New York, NY 10270 (800) 441-7468
GROUP PLAN CLAIMS
DE P.O. Box 2226, Wilmington, DE 19899 (302) 594-2000
(800) 441-7468
NY P.O. Box 512, New York, NY 10270 (212) 770-7000
OH 1375 E. 9th St., Cleveland, OH 44114 (800) 551-0824
TX P.O. Box 542528, Dallas, TX 75354 (214) 902-8500
(800) 233-8538

AMERICAN POSTAL WORKERS UNION PLAN
1300 L Street, N.W., Washington, DC 20005 (202) 842-4200

AMOCO LIFE INSURANCE CO.
306 S. 15th St., Omaha, NE 68102 (402) 344-4500

ASSOCIATED LIFE INSURANCE CO.
P.O. Box 2976, Milwaukee, WI 53201 (414) 276-8000

BANKERS LIFE & CASUALTY INSURANCE CO.
CORPORATE OFFICE
4444 W. Lawrence Ave., Chicago, IL 60630 (312) 777-7000
(800) 621-3724
GROUP CLAIMS
CA 116 Avenue I
Redondo Beach, CA 90277 (213) 378-2291
IL 5353 N. Elston Ave., Chicago, IL 60630 (312) 777-7000

BANKERS LIFE INSURANCE CO. OF AMERICA
4925 McKinney Ave., Dallas, TX 75205 (214) 521-7100

BANKERS LIFE INSURANCE CO. OF NEBRASKA
P.O. Box 81889, Lincoln, NE 68501 (800) 228-4402

BELLEFONTE UNDERWRITERS INSURANCE CO.
1221 River Bend Dr., Dallas, TX 75247 (214) 689-8333
(800) 527-2353

BENEFIT TRUST LIFE INSURANCE CO.
CORPORATE OFFICE
1771 W. Howard St., Chicago, IL 60626 (312) 274-8100
GROUP PLAN CLAIMS
542 S. Snelling Ave., St. Paul, MN 55116

BLUE CROSS & BLUE SHIELD GOVERNMENT-WIDE
550 12th St., S.W., Washington, DC 20065 (202) 484-1650

BLUE CROSS & BLUE SHIELD
AL P.O. Box 995, Birmingham, AL 35298 (205) 988-2100
FEDERAL EMPLOYEE PROGRAM
P.O. Box 10401, Birmingham, AL 35201 (800) 492-8872
BELL SOUTH DEDICATED
P.O. Box 830279
Birmingham, AL 35283 (800) 292-8802
AK P.O. Box 327, Seattle, WA 98111 (206) 361-3000
AZ P.O. Box 1200, Phoenix, AZ 85002 (602) 864-4400
AR 601 Gaines St., Little Rock, AR 72203 (501) 378-2000
CA BLUE CROSS OF SOUTHERN CALIFORNIA
P.O. Box 70000, Van Nuys, CA 91470 (818) 703-2345
BLUE CROSS OF NORTHERN CALIFORNIA
2101 Webster St., Oakland, CA 94659 (415) 645-3000
BLUE SHIELD OF CALIFORNIA
Two North Point
San Francisco, CA 94133 (415) 445-5211
CO 700 Broadway, Denver, CO 80273 (303) 831-2131
CT 370 Bassett Rd., New Haven, CT 06473 (203) 239-4911
DE P.O. Box 1991, Wilmington, DE 19899 (302) 421-3000
DC BLUE CROSS & BLUE SHIELD OF NATIONAL CAPITOL AREA
550 12th St SW, Washington, DC 20065 (202) 479-8000
FL P.O. Box 1798, Jacksonville, FL 32231 (904) 354-3331
GA P.O. Box 9907, Columbus, GA 31908 (404) 571-5371
(800) 225-3648

CHRYSLER GENERAL MOTORS & K-MART
P.O. Box 4055, Atlanta, GA 30302 (404) 842-8000
HI P.O. Box 860, Honolulu, HI 96808 (808) 944-2110
ID BLUE CROSS OF IDAHO HEALTH SERVICE, INC.
P.O. Box 7408, Boise, ID 83707 (208) 344-7411

BLUE CROSS & BLUE SHIELD (continued)

ID BLUE SHIELD OF IDAHO
P.O. Box 1106, Lewiston, ID 83501 (208) 746-2671
IL P.O. Box 1364, Chicago, IL 60690 (312) 938-7500
IN 120 W. Market Street
Indianapolis, IN 46204 (317) 263-8000
IA 636 Grand Ave., Des Moines, IA 50309 (515) 245-4500
FEDERAL EMPLOYES PROGRAM (FEP)
636 Grand Ave., Station 63
Des Moines, IA 50309 (800) 532-1537
NORTHWESTERN BELL CLAIMS
636 Grand Ave., Station 107
Des Moines, IA 50309 (800) 622-8323
PPO - ALLIANCE SELECT
636 Grand Ave., Station 10
Des Moines, IA 50309 (800) 362-2218
BLUE CROSS OF WESTERN IOWA & S. DAKOTA
Hamilton Blvd., and I-29
Sioux City, IA 51103 (712) 277-3081
KS P.O. Box 239, Topeka, KA 66629 (913) 232-1000
KY 9901 Linn Station Rd.
Louisville, KY 40223 (502) 423-2011
LA P.O. Box 98029, Baton Rouge, LA 70895 (504) 295-3307
ME 110 Free St., Portland, ME 04101 (207) 775-3536
MD 700 E. Joppa Rd., Baltimore, MD 21204 (301) 494-5555
(800) 524-4555
MA 100 Summer St., Boston, MA 02110 (617) 956-3000
MI 600 E. Lafayette, Detroit, MI 48226 (313) 225-8211
MN P.O. Box 64357, St. Paul, MN 55164 (612) 456-8000
(800) 382-2000
MS P.O. Box 1043, Jackson, MS 39215 (601) 932-3800
(800) 222-8046
MO P.O. Box 419169 (816) 395-2222
Kansas City, MO 64141 (800) 821-6181
MT P.O. Box 4309, Helena, MT 59604 (406) 444-8210
HMO MONTANA (406) 444-8250
P.O. Box 8004, Helena, MT (800) 542-6466
NE P.O. Box 3248, Omaha, NE 68180 (402) 390-1800
NV P.O. Box 10330, Reno, NV 89520 (702) 829-4000
(800) 992-6907
NH Two Pillsbury St., Concord, NH 03306 (603) 224-9511
NJ HOSPITAL SERVICE PLAN
P.O. Box 420, Newark, NJ 07102 (201) 593-2000
BLUE SHIELD
33 Washington St., Newark, NJ 07102 (201) 456-2000
NM 12800 Indian School Road., N.E.
Albuquerque, NM 87112 (505) 291-3500
FIRST SOURCE (505) 291-6939
NY HOSPITAL PLAN, INC. (315) 798-4200
245 Genesse St., Utica, NY 13501 (800) 544-1450
HOSPITAL SERVICE CORP. JEFFERSON COUNTY
158 Stone St., Watertown, NY 13601 (315) 782-2800
(800) 433-1488
NORTHEASTERN NEW YORK (518) 453-5700
P.O. Box 15013, Albany, NY 12212 (800) 888-1238
WESTERN NEW YORK
P.O. Box 80, Buffalo, NY 14240 (716) 887-6900
GREATER NEW YORK
P.O. Box 420, New York, NY 10156 (212) 490-4567
ROCHESTER AREA
150 E. Main St., Rochester, NY 14642 (716) 454-1700
CENTRAL NEW YORK
344 S. Warren St., Syracuse, NY 13221 (315) 424-3801
NC P.O. Box 2291, Durham, NC 27702 (919) 489-7431
ND 4510 13th Ave., S.W., Fargo, ND 58121 (701) 282-1100
OH HOSPITAL CARE CORPORATION
1351 William Howard Taft Rd.
Cincinnati, OH 45206 (800) 282-1016
BLUE CROSS IN CANTON
4050 Belden Village St. N.W. (216) 492-2151
Canton, OH 44716 (800) 543-4827
SOUTHWEST OHIO
1351 William Howard Taft Road (513) 872-8100
Cincinnati, OH 45206 (800) 582-1770
COMMUNITY MUTUAL INS. CO. (216) 783-2400
2400 Market St., Youngstown, OH 44507 (800) 362-2400
NORTHEAST OHIO
Hospital Claims
P.O. Box 5918, Cleveland, OH 44101 (216) 687-7000
Physicians
P.O. Box 6018, Cleveland, OH 44101 (800) 362-1279
CENTRAL OHIO (614) 464-5711
225 E. Main St., Columbus, OH 43215 (800) 722-5924
NORTHWEST OHIO (419) 473-7100
P.O. Box 956, Toledo, OH 43696 (800) 331-0512
COMMUNITY MUTUAL INS. CO. (513) 872-8100
P.O. Box 425, Worthington, OH 43805 (800) 582-1770
OK P.O. Box 3283, Tulsa, OK 74102 (918) 583-0861
OR P.O. Box 1271, Portland, OR 97207 (503) 225-5221
PA LEHIGH VALLEY
1221 Hamilton, Allentown, PA 18102 (215) 820-2700
CAPITAL BLUE CROSS
100 Pine St., Harrisburg, PA 17101 (717) 255-6000
INDEPENDENT BLUE CROSS
1333 Chestnut, Philadelphia, PA 19107 (215) 448-5000
WESTERN PENNSYLVANIA
One Smithfield, Pittsburgh, PA 15222 (412) 391-8540
NORTHEASTERN PENNSYLVANIA
70 N. Main, Wilkes-Barre, PA 18711 (717) 829-8500
PENNSYLVANIA BLUE SHIELD
1800 Center St., Camp Hill, PA 17011 (717) 829-8500
RI 444 Westminister Mall (401) 272-8500
Providence, RI 02901 (800) 527-7290
SC P.O. Drawer F, Columbia, SC 29260 (803) 788-3860
(800) 845-3492
SD WESTERN IOWA & SOUTH DAKOTA
Hamilton Blvd. & I-29
Sioux City, IA 51103 (712) 277-3081
BLUE SHIELD OF SOUTH DAKOTA
1601 W Madison, Sioux Falls, SD 57104 (605) 336-1976
TN 801 Pine St., Chattanooga, TN 37402 (615) 755-5600
MEMPHIS HOSPITAL SERV., & SURGICAL ASSN.
P.O. Box 98, Memphis, TN 38101 (901) 529-3111
(800) 222-7212
TX P.O. Box 655730, Richardson, TX 75265 (214) 669-6900
(800) 962-2854
UT P.O. Box 30270 (801) 487-6441
Salt Lake City, UT 84130 (800) 662-6516
VT P.O. Box 186, Montpelier, VT 05602 (802) 223-6131
VA P.O. Box 27287, Richmond, VA 23261 (804) 359-7000
(800) 451-1527

BLUE CROSS & BLUE SHIELD (continued)

SOUTHWESTERN VIRGINIA (703) 985-5000
P.O. Box 13047, Roanoke, VA 24025 (800) 553-1120

WA P.O. Box 327, Seattle, WA 98111 (206) 367-1419
KING COUNTY MEDICAL
P.O. Box 21267, Seattle, WA 98111 (206) 464-3600
PHYSICIANS SERVICE
2401 Fourth Ave., Seattle, WA 98121 (206) 441-9370
MEDICAL SERV. CORP. EASTERN (509) 536-4700
P.O. Box 3048, Spokane, WA 99220 (800) 835-3510
PIERCE COUNTY MEDICAL BUREAU
1114 Broadway Plaza
Tacoma, WA 98402 (206) 597-6500

WV P.O. Box 1353, Charleston, WV 25321 (304) 347-7600
(800) 543-7822

WEST CENTRAL
P.O. Box 1948, Parkersburg, WV 26102 (304) 424-7700

WI 401 W. Michigan Street
Milwaukee, WI 53201 (414) 224-6100
PHYSICIANS SERVICE (608) 221-4711
P.O. Box 8190, Madison, WI 53708 (800) 356-8051

WY 4000 House Ave., Cheyenne, WY 82003 (307) 634-1393
(800) 442-2376

BUSINESS MENS ASSURANCE CO. OF AMERICA
P.O. Box 419407, Kansas City, MO 64141 (816) 753-8000
(800) 262-5433

CENTRAL STATES HEALTH & LIFE INSURANCE CO. OMAHA
P.O. Box 34350, Omaha, NE 68134 (402) 397-1111

CENTRAL STATES S.E. & S.W. WELFARE FUND
8550 W. Bryn Mawr Ave., Chicago, IL 60631-3275

CHAMPUS (PHYSICIANS) ALABAMA
BLUE CROSS (BC) & BLUE SHIELD (BS)
OF SOUTH CAROLINA (803) 736-1320
P.O. Box 100502
Florence, SC 29501-7986 (800) 476-2500

CHAMPUS (PHYSICIANS) ALASKA
BC & BS OF SOUTH CAROLINA (206) 771-1199
P.O. Box 100502
Florence, SC 29501-0502 (800) 225-4816

CHAMPUS (PHYSICIANS) ARIZONA
BC & BS OF SOUTH CAROLINA (803) 736-1320
P.O. Box 100502
Florence, SC 29501-0502 (800) 225-4816

CHAMPUS (PHYSICIANS) ARKANSAS
WISCONSIN PHYSICIANS SERVICE (608) 221-4711
P.O. Box 7938, Madison, WI 53707 (800) 356-5954

CHAMPUS (PHYSICIANS) CALIFORNIA
BC & BS OF SOUTH CAROLINA
P.O. Box 100502
Florence, SC 29501-0502 (803) 799-0777

CHAMPUS (PHYSICIANS) COLORADO
BC & BS OF SOUTH CAROLINA
P.O. Box 100502
Florence, SC 29501-0502 (800) 225-4816

CHAMPUS (PHYSICIANS) CONNECTICUT
THE ASSOCIATED GROUP (206) 771-1199
P.O. Box 3066, Columbus, IN 47202 (800) 842-4333

CHAMPUS (PHYSICIANS) DELAWARE
BC & BS OF SOUTH CAROLINA (803) 736-1320
P.O. Box 100502, Florence, SC 29501 (800) 476-2500

CHAMPUS (PHYSICIANS) DISTRICT OF COLUMBIA
BC & BS OF SOUTH CAROLINA (803) 736-1320
P.O. Box 100502, Florence, SC 29501 (800) 476-2500

CHAMPUS (PHYSICIANS) FLORIDA
BC & BS OF SOUTH CAROLINA (803) 736-1320
P.O. Box 100502
Florence, SC 29501-7889 (800) 476-2500

CHAMPUS (PHYSICIANS) GEORGIA
BC & BS OF SOUTH CAROLINA (803) 736-1320
P.O. Box 100502
Florence, SC 29501-7891 (800) 476-2500

CHAMPUS (PHYSICIANS) HAWAII
BC OF WASHINGTON & ALASKA
P.O. Box 77084, Seattle, WA 98124 (800) 426-1337

CHAMPUS (PHYSICIANS) IDAHO
BC & BS OF SOUTH CAROLINA (206) 771-1199
P.O. Box 100502
Florence, SC 29501-0502 (800) 225-4816

CHAMPUS (PHYSICIANS) ILLINOIS
THE ASSOCIATED GROUP (812) 379-5000
P.O. Box 3054, Columbus, IN 47202 (800) 842-4333

CHAMPUS (PHYSICIANS) INDIANA
THE ASSOCIATED GROUP (812) 379-5000
P.O. Box 3056, Columbus, IN 47202 (800) 842-4333

CHAMPUS (PHYSICIANS) IOWA
THE ASSOCIATED GROUP (812) 379-5000
P.O. Box 3058, Columbus, IN 47202 (800) 842-4333

CHAMPUS (PHYSICIANS) KANSAS
WISCONSIN PYSICIANS SERVICE (608) 221-4711
P.O. Box 7934, Madison, WI 53707 (800) 356-5954

CHAMPUS (PHYSICIANS) KENTUCKY
THE ASSOCIATED GROUP (812) 379-5000
P.O. Box 3061, Columbus, IN 47202 (800) 842-4333

CHAMPUS (PHYSICIANS) LOUISIANA
WISCONSIN PYSICIANS SERVICE (608) 221-4711
P.O. Box 8934, Madison, WI 53708 (800) 356-5954

CHAMPUS (PHYSICIANS) MAINE
THE ASSOCIATED GROUP (812) 379-5000
P.O. Box 3064, Columbus, IN 47202 (800) 842-4333

CHAMPUS (PHYSICIANS) MARYLAND
BC & BS OF SOUTH CAROLINA (803) 736-1320
P.O. Box 100502, Florence, SC 29501 (800) 466-8500

CHAMPUS (PHYSICIANS) MASSACHUSETTS
THE ASSOCIATED GROUP (812) 379-5000
P.O. Box 3063, Columbus, IN 47202 (800) 842-4333

CHAMPUS (PHYSICIANS) MICHIGAN
THE ASSOCIATED GROUP (812) 379-5000
P.O. Box 3053, Columbus, IN 47202 (800) 842-4333

CHAMPUS (PHYSICIANS) MINNESOTA
THE ASSOCIATED GROUP (812) 379-5000
P.O. Box 3057, Columbus, IN 47202 (800) 842-4333

CHAMPUS (PHYSICIANS) MISSISSIPPI
BC & BS OF SOUTH CAROLINA (803) 736-1320
P.O. Box 100502
Florence, SC 29501-7957 (800) 466-2500

CHAMPUS (PHYSICIANS) MISSOURI
WISCONSIN PYSICIANS SERVICE (608) 221-4711
P.O. Box 7934, Madison, WI 53708 (800) 356-5954

CHAMPUS (PHYSICIANS) MONTANA
BC & BS OF SOUTH CAROLINA (206) 771-1199
P.O. Box 100502
Florence, SC 29501-0502 (800) 225-4816

CHAMPUS (PHYSICIANS) NEBRASKA
BC & BS OF SOUTH CAROLINA (206) 771-1199
P.O. Box 100502
Florence, SC 29501-0502 (800) 225-4816

CHAMPUS (PHYSICIANS) NEVADA
BC & BS OF SOUTH CAROLINA (803) 736-1320
P.O. Box 100502, Florence, SC 29501 (800) 225-4816

CHAMPUS (PHYSICIANS) NEW HAMPSHIRE
THE ASSOCIATED GROUP (812) 379-5000
P.O. Box 3067, Columbus, IN 47202 (800) 842-4333

CHAMPUS (PHYSICIANS) NEW JERSEY
THE ASSOCIATED GROUP (812) 379-5000
P.O. Box 3052, Columbus, IN 47202 (800) 842-4333

CHAMPUS (PHYSICIANS) NEW MEXICO
BC & BS OF SOUTH CAROLINA (803) 736-1320
P.O. Box 100502, Florence, SC 29501 (800) 225-4816

CHAMPUS (PHYSICIANS) NEW YORK
THE ASSOCIATED GROUP
Zips 13000-14999 (812) 379-5000
P.O. Box 3050, Columbus, IN 47202
Zips 10000-12999 (800) 842-4333
P.O. Box 3051, Columbus, IN 47202

CHAMPUS (PHYSICIANS) NORTH CAROLINA
BC & BS OF SOUTH CAROLINA (803) 736-1320
P.O. Box 100502, Florence, SC 29501 (800) 476-2500

CHAMPUS (PHYSICIANS) NORTH DAKOTA
BC & BS OF SOUTH CAROLINA (206) 771-1199
P.O. Box 100502
Florence, SC 29501-0502 (800) 225-4816

CHAMPUS (PHYSICIANS) OHIO
THE ASSOCIATED GROUP
Zips 43700-44799 (812) 379-5000
P.O. Box 3060, Columbus, IN 47202
All Other Zips (800) 842-4333
P.O. Box 3059, Columbus, IN 47202

CHAMPUS (PHYSICIANS) OKLAHOMA
WISCONSIN PYSICIANS SERVICE (608) 221-4711
P.O. Box 7934, Madison, WI 53707 (800) 356-5954

CHAMPUS (PHYSICIANS) OREGON
BC & BS OF SOUTH CAROLINA (206) 771-1199
P.O. Box 100502
Florence, SC 29501-0502 (800) 225-4816

CHAMPUS (PHYSICIANS) PENNSYLVANIA
BC & BS OF SOUTH CAROLINA (803) 736-1320
P.O. Box 100502, Florence, SC 29501 (800) 476-2500

CHAMPUS (PHYSICIANS) RHODE ISLAND
THE ASSOCIATED GROUP (812) 379-5000
P.O. Box 3065, Columbus, IN 47202 (800) 842-4333

CHAMPUS (PHYSICIANS) SOUTH CAROLINA
BC & BS OF SOUTH CAROLINA (803) 736-1320
P.O. Box 100502, Florence, SC 29501 (800) 476-2500

CHAMPUS (PHYSICIANS) SOUTH DAKOTA
BC & BS OF SOUTH CAROLINA (206) 771-1199
P.O. Box 100502
Florence, SC 29501-0502 (800) 225-4816

CHAMPUS (PHYSICIANS) TENNESSEE
BC & BS OF SOUTH CAROLINA (803) 736-1320
P.O. Box 100502
Florence, SC 29501-7984 (800) 476-2500

CHAMPUS (PHYSICIANS) TEXAS
WISCONSIN PYSICIANS SERVICE (608) 221-4711
P.O. Box 8932, Madison, WI 53708 (800) 356-5954

CHAMPUS (PHYSICIANS) UTAH
BC & BS OF SOUTH CAROLINA (206) 771-1199
P.O. Box 100502
Florence, SC 29501-0502 (800) 225-4816

CHAMPUS (PHYSICIANS) VERMONT
THE ASSOCIATED GROUP (812) 379-5000
P.O. Box 3068, Columbus, IN 47202 (800) 842-4333

CHAMPUS (PHYSICIANS) VIRGINIA
BC & BS OF SOUTH CAROLINA (803) 736-1320
P.O. Box 100502, Florence, SC 29501 (800) 466-8500

CHAMPUS (PHYSICIANS) WASHINGTON
BC & BS OF SOUTH CAROLINA (206) 771-1199
P.O. Box 100502
Florence, SC 29501-0502 (800) 225-4816

CHAMPUS (PHYSICIANS) WEST VIRGINIA
THE ASSOCIATED GROUP (812) 379-5000
P.O. Box 3062, Columbus, IN 47202 (800) 842-4333

CHAMPUS (PHYSICIANS) WISCONSIN
THE ASSOCIATED GROUP (812) 379-5000
P.O. Box 3055, Columbus, IN 47202 (800) 842-4333

CHAMPUS (PHYSICIANS) WYOMING
BC & BS OF SOUTH CAROLINA (206) 771-1199
P.O. Box 100502
Florence, SC 29501-0502 (800) 225-4816

CHILDREN WITH HANDICAPS (SERVICES TO)
717 Delaware, P.O. Box 9441
Minneapolis, MN 55440 (612) 612-5150

CHUBB LIFEAMERICA INSURANCE CO. OF AMERICA
CORPORATE OFFICE
1 Granite Place, Concord, NH 03301 (603) 224-7741
GROUP PLAN CLAIMS
FL P.O. Box 371068, Miami, FL 33137 (305) 754-3291
MN 654 Pillsbury Center
Minneapolis, MN 55402 (612) 388-5501
NH P.O. Box 2023, Concord, NH 03302 (603) 228-1203
NJ P.O. Box 328, Parsippany, NJ 07054 (201) 455-1400
TN P.O. Box 551, Chattanooga, TN 37402 (615) 756-2887

CIGNA COMPANIES
CORPORATE OFFICE
1600 Arch St., Philadelphia, PA 19103 (215) 523-4000
GROUP PLAN CAIMS
CA P.O. Box 9105, Walnut Creek, CA 94598 (415) 945-0880
IL 525 W. Monroe St., Chicago, IL 60606 (312) 648-2330
NY 127 John St., New York, NY 10038 (212) 440-6800
PA 1101 Market St., Philadelphia, PA 19107 (215) 523-2340
TX 12225 Greenville Ave., 75243
Dallas, TX 75243 (214) 869-8700

CIGNA HEALTH INSURANCE
CORPORATE OFFICE
Connecticut General Bldg.
Hartford, CT 06152 (203) 726-6000
GROUP PLAN CLAIMS
CA 9808 Scranton Road (619) 458-4000
San Diego, CA 92121 (800) 888-2091
P.O. Box 8765
Universal City, CA 91608 (209) 738-2000
P.O. Box 5020, Visalia, CA 93291 (800) 888-2091
CA P.O. Box 9105
Walnut Creek, CA 94598 (415) 945-0880
CO 950 Cherry St., Denver, Co 80222 (303) 691-0851
(800) 821-4727
CT UTC Medical Claims (203) 561-3750
Hartford, CT 06152 (800) 243-8552
80 Spring Ln., Plainville, CT 06062 (203) 747-4591
(800) 888-2033
DE P.O. Box 6006, Newark, DE 19714 (302) 738-9771
FL P.O. Box 6468, Lakeland, FL 33807 (813) 644-0462
(800) 777-8131
GA P.O. Box 29000, Atlanta, GA 30359 (404) 934-9920
(800) 999-0196
P.O. Box 450609, Atlanta, GA 30345 (404) 934-9980
(800) 999-0196
IL P.O. Box 2100, Bourbonnais, IL 60914 (815) 939-4566
(800) 777-8151
525 W. Monroe, Chicago, IL 60606 (312) 984-5700
MD 201 International Circle (301) 785-6800
Hunt Valley, MD 21031 (800) 333-2722
MI P.O. Box 2305, Southfield, MI 48034 (313) 354-8330
MO 3100 Broadway, Kansas City, MO 64111 (816) 932-9300
NY 263 Route 17K, Newburg, NY 12550 (914) 564-3400
(800) 431-4949
127 John St., New York, NY 10038 (212) 440-4074
25 Franklin St., Rochester, NY 14604 (716) 258-1744
P.O. Box 9009, Jericho, NY 17793 (516) 496-7840
OH 600 Vine St., Cincinnati, OH 45202 (513) 621-4343
(800) 777-5131
PA 45 North 2nd St., Easton, PA 18042 (215) 258-7183
1101 Market St., Philadelphia, PA 19107 (215) 523-4000
600 Grant St., Pittsburgh, PA 15219 (412) 456-7915
(800) 777-4121
TX 12225 Greenville, Lockbox 179
Dallas, TX 75243 (214) 234-3404
P.O. Box 2546, Sherman, TX 75091 (214) 892-8167
(800) 777-2141
WI P.O. Box 081100, Racine, WI 53406 (414) 886-3340

COMMERCIAL BANKERS LIFE INSURANCE CO.
P.O. Box 8340, Newport Beach, CA 92658 (714) 833-8450

COMMONWEALTH LIFE INSURANCE CO. OF KENTUCKY
CORPORATE OFFICE
P.O. Box 32800, Louisville, KY 40232 (502) 587-7371
PRIVATE PLAN CLAIMS
FL P.O. Box 991, Orlando, FL 32802 (407) 295-0945
GA P.O. Box 7325, Atlanta, GA 30357 (404) 552-8122
NC P.O. Box 61, Durham, NC 27702 (919) 682-5431
(800) 444-5431

CONSOLIDATED BENEFIT HEALTH LIFE INS. CO.
6210 Campbell Rd., Dallas, TX 75248 (214) 380-1436
(800) 527-0917

CONNECTICUT GENERAL LIFE INSURANCE CO.
Connecticut Gen. Bldg., Hartford, CT 06152 (203) 726-6000

CONSTRUCTION SUPPLIERS TRUST
1221 Nicollet Mall #221
Minneapolis, MN 55403 (612) 375-9055

CONTINENTAL ASSURANCE CO.
CORPORATE OFFICE
CNA Plaza, Chicago, IL 60685 (312) 822-5000
PRIVATE PLAN CLAIMS
FL P.O. Box 593925, Orlando, FL 32859 (305) 859-2100
(800) 327-2430

GROUP PLAN CLAIMS
CA P.O. Box 30105
Los Angeles, CA 90030 (213) 252-7117
(800) 262-0213
GA P.O. Box 3200, Atlanta, GA 30302 (404) 493-6178
(800) 282-7084
IL CNA Plaza, Chicago, IL 60685 (312) 822-5940
KS 7900 College Blvd.
Overland Park, KS 66210 (913) 661-2830
P.O. Box 2937
Shawnee Mission, KS 66210 (913) 661-2830
MI 30200 Telegraph Road (313) 645-6945
Birmingham, MI 48010 (800) 288-2625
NJ P.O. Box 245, Parsippany, NJ 07054 (201) 515-6400
(800) 262-0713
TX 213 W. Southmore, Pasadena, TX 77502 (713) 477-7143
(800) 262-0713
WI 245 S. Executive Dr.
Brookfield, WI 53005 (414) 786-7575

SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS
AL 2127 E. South Blvd.
Montgomery, AL 36199 (205) 288-0220
AK 1231 Gamble St., Anchorage, AK 99501 (907) 274-7626
AZ 1740 West Adams, Room 205
Phoenix, AZ 85007 (602) 542-2822
AR P.O. Box 1437, Little Rock, AR 72203 (501) 682-8770
(800) 482-5964
CA 741-744 P St., Room 323
Sacramento, CA 95814 (916) 322-2090
CO 4210 E. 11th Ave., Denver, CO 80200 (303) 331-8402
CT 150 Washington St., Hartford, CT 06106 (203) 566-2057
DE P.O. Box 637, Dover, DE 19903 (302) 736-4735
DC 19th & Mass. Ave., S.E. B-10 (202) 675-5214
Washington, DC 20003 (800) 724-4318
FL 1323 Winewood Blvd. B-5 R-127
Tallahassee, FL 32399 (904) 487-2690
GA 2600 Skyland Dr., Atlanta, GA 30319 (404) 320-0547
HI 741 Sunset Ave., Honolulu, HI 96816 (808) 735-9003
ID 450 W. State, Boise, ID 83720 (208) 334-5962
IL 2040 Hill Meadows Dr., (217) 793-2350
Springfield, IL 62702 (800) 322-3722
IN 238 South Maridian St.
Indianapolis, IN 46225 (317) 232-4283
IA Hospital School Building
Iowa City, IA 52242 (319) 356-1616
KS 900 SW Jackson, Landon Building (913) 296-1313
Topeka, KS 66612 (800) 332-6262
KY 982 Eastern Pky., Louisville, KY 40217 (502) 588-3264
LA P.O. Box 60630
New Orleans, LA 70160 (504) 568-5055
ME 157 Capital St., Augusta, ME 04333 (207) 289-3311
(800) 437-9300
MD 201 W. Preston Street, 4th Floor
Baltimore, MD 21201 (301) 225-5580
MA 150 Tremont, Boston, MA 02111 (617) 727-5812
MI P.O. Box 30195, Lansing, MI 48909 (517) 335-8961
MN 717 Delaware St., S.E.
Minneapolis, MN 55440 (612) 623-5150
MS P.O. Box 1700, Jackson, MS 39205 (601) 960-7613
(800) 843-0898
MO P.O. Box 570, Jefferson City, MO 65102 (314) 751-6246
(800) 877-6246
MT Cogswell Bldg., Helena, MT 59620 (406) 444-4740
NE 301 Centennial Mall S., 5th Floor (402) 471-9310
NV 505 E. King St., Carson City, NV 89710 (702) 885-4885
NH 40 Terrill Park Dr., Concord, NH 03301 (603) 271-6200
NJ 363 W. State St., Trenton, NJ 08625 (609) 292-5676
NM 230 W. Manhattan, Santa Fe, NM 87501 (505) 827-8890
NY Tower Bldg., Empire State Plaza
Albany, NY 12237 (518) 447-4615
NC P.O. Box 27687, Raleigh, NC 27611 (919) 733-7437
ND State Capitol Bldg., 600 E Blvd. (701) 224-2436
Bismark, ND 58505 (800) 472-2622
OH P.O. Box 118, Columbus, OH 43266 (614) 466-1700
OK P.O. Box 25352
Oklahoma City, OK 73125 (405) 557-2539
OR 707 S.W. Gaines Road
Portland, OR 97201 (503) 279-8811
PA P.O. Box 90, Harrisburg, PA 17108 (717) 783-5436
(800) 852-4453
RI 3 Capital Ave., Providence, RI 02908 (401) 277-2312
SC 2600 Bull St., Columbia, SC 29201 (803) 734-4610
SD 523 East Capitol, Pierre, SD 57501 (605) 773-3737
TN 525 Cordell Hall Bldg.
Nashville, Tn 37219 (615) 741-7353
TX 1100 W. 49th St., Austin, TX 78756 (512) 458-7355
(800) 252-8023
UT P.O. Box 16650
Salt Lake City, UT 84116 (801) 538-6165
VT P.O. Box 70, Burlington, VT 05402 (802) 863-7330
VA 109 Governor St., Richmond, VA 23219 (804) 786-3691
WA Industrial Park, Building 7, MS LC11B
Olympia, WA 98504 (206) 753-7002
WV 1116 Quarrier, Charleston, WV 25301 (304) 348-3071
WI P.O. Box 7841, Madison, WI 53707 (608) 266-3886
WY Hathaway Office Bldg.
Cheyenne, WY 82002 (307) 777-7948

CONTINENTAL LIFE & ACCIDENT INSURANCE CO.
CORPORATE OFFICE
P.O. Box 020270, Miami, FL 33102 (305) 591-8511
PRIVATE PLAN CLAIMS
P.O. Box 1599, Boise, ID 83701 (208) 345-7770
GROUP PLAN CLAIMS
5100 Gamble Dr., St. Louis Park, MN 55481 (612) 541-6400

CORPORATE BENEFITS SERVICE OF AMERICA, INC.
1415 Lilac Drive, Minneapolis, MN 55422 (612) 546-9345

CUNA MUTUAL INSURANCE
P.O. Box 16458, Madison, WI 53701 (608) 231-7259

DCA HEALTH CARE MANAGEMENT
13100 Wayzata Blvd., Minnetonka, MN 55343

ELECTRICAL WORKER'S IBEW #292
2101 Hennepin Ave., Minneapolis, MN 55405

EQUICOR
CORPORATE OFFICE
195 Broadway, New York, NY 10007 (800) 782-9355
GROUP PLAN CAIMS
AZ P.O. Box 16543, Phoenix, AZ 85014 (602) 241-0433
CA 1630 E. Shaw Ave., Fresno, CA 93710 (209) 228-2889
P.O. Box 445, Lafayette, CA 94549 (415) 284-2730
CO P.O. Box 529,
Colorado Springs, CO 80903 (719) 632-3300
IA 1501 50th St., W Des Moines, IA 50265 (515) 223-9600
(800) 223-5601
IL 10W51 Frontage Rd., Lemont, IL 60439 (312) 910-2304
IN 1000 East 80th Pl., Merrillville, IN 46410 (219) 769-3406
KS 4220 Shawnee Mission Parkway
Shawnee Mission, KS 66205 (913) 384-4600
MN 400 Sibley St., St. Paul, Mn 55101 (612) 292-8800
(800) 292-9902
NM P.O. Box 3310, Albuquerque, NM 87190 (505) 345-8941
NY 1055 Franklin Ave.
Garden City, NY 11530 (516) 745-1240
OH 7991 Columbus Pike
Delaware, OH 43015 (614) 548-4060
PA 4 Gateway Center, Pittsburgh, PA 15222 (412) 562-2960
PR 255 Ponce de Leon Ave.
Hato Rey, PR 99017 (809) 753-0033
VA P.O. Box 2V, Richmond, VA 23205 (804) 771-1800
WA P.O. Box 75984, Northgate Station
Seattle, WA 98125 (206) 527-5420

EQUITABLE LIFE, GROUP & HEALTH INS. CO.
CORPORATE OFFICE
195 Broadway, New York, NY 10007 (800) 782-9355
GROUP PLAN CLAIMS
400 Sibley St., St. Paul, MN 55101 (612) 292-8000

FEDERATED MUTUAL INSURANCE CO.
CORPORATE OFFICE
121 Park Square, Owatonna, MN 55060 (800) 533-0472
GROUP PLAN CLAIMS
FL P.O. Box 31716, Tampa, FL 33631 (813) 877-5721
(800) 237-8292
IA P.O. Box 65509,
West Des Moines, IA 50265 (515) 225-6661
IN P.O. Box 50487 Castleton Dr.
Indianapolis, IN 46250 (317) 849-7550
MN 4570 West 77th St.
Minneapolis, MN 55435 (612) 831-4330
MN 129 E. Broadway, Owatonna, MN 55060 (507) 451-1320
MO P.O. Box 444, Kansas City, MO 64141 (816) 561-7777
TX P.O. Box 1548, Hurst, TX 76053 (817) 581-7111
(800) 999-9915

FIREMANS FUND AMERICAN LIFE INS. CO.
CORPORATE OFFICE
P.O. Box 3650, San Rafael, CA 94912 (415) 492-7405
GROUP PLAN CLAIMS
300 S. Riverside Plaza, Chicago, IL 60606 (312) 207-3222

GREAT WEST LIFE ASSURANCE CO.
CORPORATE OFFICE
8505 E. Orchard Rd., Englewood, CO 80111 (204) 946-1190
GROUP PLAN CLAIMS
CA 225 W. Broadway, Glendale, CA 91209 (800) 232-2750
333 Market St.
San Francisco, CA 94105 (800) 232-9750
CO P.O. Box 950, Denver, CO 80201 (800) 525-1626
GA 3340 Peachtree Road, N.E. (404) 266-3741
Atlanta, GA 30326 (800) 372-7415
IL 230 W. Monroe St., Chicago, IL 60606 (800) 621-7226
MI 200 Renaissance Center
Detroit, MI 48243 (313) 259-6480
MN 7151 Metro Blvd.
Minneapolis, MN 55435 (800) 328-3902
MO 7700 Bonhomme Ave. (314) 727-7470
Clayton, MO 63105 (800) 392-0746
OH 1377 Dublin Rd., Columbus, OH 43215 (800) 848-3452
OR 1800 S.W. 1st Ave., Portland, OR 97201 (503) 224-0140
(800) 622-3336
PA P.O. Box 1000, Forsham, PA 19044 (800) 523-4207

GUARDIAN LIFE INSURANCE CO. OF AMERICA
CORPORATE OFFICE
201 Park Ave. South, New York, NY 10003 (212) 598-8000
GROUP PLAN CLAIMS
GA 1800 Peachtree St. N.W. (404) 352-3690
Atlanta, GA 30348 (800) 624-6215
MA 700 Longwater Dr., Norwell, MA 02061 (617) 871-4890
NJ 1373 Broad St., Clifton, NJ 07013 (800) 341-1023
NY policies, P.O. 3133, Nehigh, PA 18001
NJ policies, P.O. 3033, Nehigh, PA 18001
NY 105 Madison Ave.
New York, NY 10016 (212) 598-8808
PA NY policies, P.O. 3133
Nehigh, PA 18001 (215) 861-6200
NJ policies, P.O. Box 3133, Neigh, PA 18001
1 Franklin Plaza, Philadelphia, PA 19102 (800) 624-6215

GULF LIFE INSURANCE CO./AMERICAN GENERAL
CORPORATE FOFICE
1301 Gulf Life Dr., Jacksonville, FL 32207 (904) 390-7000
(800) 888-5256
GROUP PLAN CLAIMS
FL 6363 Northwest 6th Way (305) 772-6666
Ft. Lauderdale, FL 33309 (800) 345-7498
P.O. Box 2568, Jacksonville, FL 32203 (904) 390-7100
(800) 888-5256
2114 Airport Blvd., Pensacola, FL 32504 (904) 478-3726

GULF LIFE INSURANCE CO./AMERICAN GENERAL (continued)

FL 4511 N. Himes Ave., Tampa, FL 33614 (813) 877-7443
(800) 652-9970
GA 1100 Ashwood Parkway (404) 395-4748
Atlanta, GA 30338 (800) 652-9970
MD 3910 Keswick Rd., Baltimore, MD 21211 (301) 338-9824
TN American General CTR, MC1605
Nashville, TN 37250 (615) 749-1000
TX P.O. Box 660238, Dallas, TX 75266 (214) 824-0131
(800) 888-8024

HARTFORD LIFE INSURANCE CO.

CORPORATE OFFICE
Hartford Plaza, Hartford, CT 06115 (203) 547-5000
PRIVATE PLAN CLAIMS
P.O. Box 2999, Hartford, CT 06104 (203) 683-8600
GROUP PLAN CLAIMS
CA P.O. Box 4878 (714) 595-1983
Diamond Bar, CA 91765 (800) 472-5993
MULTIPLE EMPLOYERS TRUST
GA P.O. Box 888820, Atlanta, GA 30356 (404) 256-1155
(800) 282-5855
P.O. Box 14509, Savannah, GA 31416 (912) 354-4668
IL P.O. Box 5002, Bowlingbrook, IL 60439 (312) 759-5055
KS P.O. Box 29164 (913) 451-2324
Shawnee Mission, KS 66201 (800) 255-6440
NJ 11 Commerce Dr., Cranford, NJ 07016 (201) 272-3960
(800) 526-6905
NY P.O. Box 4925, Syracuse, NY 13221 (315) 474-6431
(800) 448-5813
TX P.O. Box 927, Dallas, TX 75221 (214) 980-1900
(800) 443-0124
VA P.O. Box 11910, Alexandria, VA 22312 (703) 824-0600
(800) 368-3653

HOME INSURANCE CO.

7600 France Ave. S.
P.O. Box 35827, Minneapolis, MN 55435

HORACE MANN LIFE INSURANCE CO.

1 Horace Mann Plaza, Springfield, IL 62715 (217) 789-2500

INDEPENDENT INSURANCE CO.

12450 Wayzata Blvd., Minnetonka, MN 55343

ITT LIFE INSURANCE CORP.

600 S. County Rd. 18
Minneapolis, MN 55426 (612) 545-2100

JEFFERSON PILOT LIFE INSURANCE CO.

CORPORATE OFFICE
Inv. Box 20727, Greensboro, NC 27420 (919) 547-4000
Grp. Box 26011
GROUP PLAN CLAIMS
CA 3450 Wilshire Blvd.
Los Angeles, CA 90010 (213) 386-3324
FL P.O. Box 1561, Lake City, FL 32056 (904) 755-7511
PR P.O. Box 878, Hato Rey, PR 00919 (809) 753-7565
TN 4711 Trousdale Drive
Nashville, TN 37220 (615) 331-3150
TX 10101 Southwest Fwy.
Houston, TX 77074 (713) 776-1761

JOHN ALDEN LIFE INSURANCE CO.

CORPORATE OFFICE
7300 Corporate Center Dr., Miami, FL 33178 (305) 594-3400
GROUP PLAN CLAIMS
FL 7300 Corporate Center Drive (305) 470-3100
Miami, FL 33126 (800) 328-4316
ID P.O. Box 1599, Boise, ID 83701 (208) 345-2020
(800) 328-4316
MN P.O. Box 9398, Minneapolis, MN 55440 (612) 541-6400
OH P.O. Box 1804, Dublin, OH 43017 (614) 761-6300
(800) 328-4316

JOHN HANCOCK MUTUAL LIFE INSURANCE CO.

CORPORATE OFICE
P.O. Box 111, Boston, MA 02117 (800) 426-2273
GROUP PLAN CLAIMS
CA P.O. Box 60866, Terminal Annex
Los Angeles, CA 90060 (213) 380-1200
399 Taylor Blvd.
Pleasant Hill, CA 94523 (415) 827-5830
GA 200 Hanover Park Road
Dunwoody, GA 30356 (404) 641-5700
IL P.O. Box 4005, Schaumburg, IL 60168 (312) 706-4050
IN P.O. Box 55227, Indianapolis, IN 46205 (317) 848-7779
NH 300 Hanover St., Manchester, MA 03104 (800) 258-5284
DIGITAL EQUIPMENT CORP.
MA P.O. Box 1000, Braintree, MA 02184 (617) 848-9520
(800) 332-2060

LONG TERM DISABILITY
MA 525 Salem St., Lynnfield, MA 01940 (617) 581-8300
FORD
MI 10845 W. Warren, Dearborn, MI 48126 (313) 584-1900
(800) 843-8184
P.O. Box 33930-A, Detroit, MI 48323 (313) 553-6700
6054 Lovers Ln., Kalamazoo, MI 49002 (616) 323-3476
MN 121 South 8th Street
Minneapolis, MN 55402 (612) 339-8595
ASSOCIATIONS ONLY
MO P.O. Box 120, Ballwin, MO 63022 (314) 821-3002
NC 5 Centerview Dr., Greensboro, NC 27407 (919) 854-2900
NH 300 Hanover St., Manchester, NH 03104 (603) 624-3800
OH 300 E. Wilson Ridge Road
Worthington, OH 48085 (614) 846-6000
OR 720 S.W. Washington St. (503) 228-9311
Portland, OR 97205 (800) 547-6735
COMBUSTION ENGINEERS
PA 1585 Paoli Pike, Box 2680
Westchester, PA 19380 (215) 344-7780

LIBERTY MUTUAL INSURANCE CO.

CORPORATE OFFICE
175 Berkeley St., Boston, MA 02117 (617) 357-9500
GROUP PLAN CLAIMS
CA P.O. Box 5014, Fresno, CA 93784 (209) 224-6110
GA P.O. Box 2817, Gainesville, GA 30503 (404) 536-8761
(800) 241-1121

LIBERTY MUTUAL INSURANCE CO. (continued)

IN	1 Liberty Square, Mishawaka, IN 46544	(219) 258-4400
		(800) 348-2478
NY	260 Middle County Road	(516) 724-9100
	Smithtown, NY 11787	(800) 645-5178
PA	2501 Wilmington Road	(412) 658-3771
	New Castle, PA 16105	(800) 245-1700

LIFE INSURANCE CO. OF NORTH AMERICA

CORPORATE OFFICE

Five Penn Center Plaza
Philadelphia, PA 19103 (215) 569-7790

GROUP PLAN CLAIMS

1 S. Wacker Dr., Chicago, IL 60606 (312) 750-6810

LINCOLN NATIONAL LIFE INSURANCE CO.

CORPORATE OFFICE

1300 S. Clinton St., Fort Wayne, IN 46801 (219) 427-2000

PRIVATE PLAN CLAIMS

P.O. Box 1110, Fort Wayne, IN 46801 (219) 427-2000

GROUP PLAN CLAIMS

CA	3875 Hoy Yard Road	(415) 847-7296
	Pleasanton, CA 94566	(800) 451-0386
CO	P.O. Box 4940	(719) 590-6400
	Colorado Springs, CO 80949	(800) 331-0643
IN	P.O. Box 1110, Fort Wayne, IN 46801	(219) 427-4831
		(800) 348-4916
KS	P.O. Box 5001, Ft. Scott, KS 66701	(316) 223-0090
		(800) 826-2898
MD	5310 A Spectrum Drive	(301) 428-3636
	Frederick, MD 21701	(800) 626-5540
MN	4510 West 77th Street	
	Minneapolis, MN 55435	(612) 835-2822

LOCAL 792 CLAIMS DEPARTMENT

3001 University Ave., S.E., Minneapolis, MN 55414

LOCAL NO. 638 HEALTH & WELFARE

3001 University Ave. S.E.
Minneapolis, MN 55414 (612) 379-9157

LUTHERAN BROTHERHOOD INSURANCE CO.

625 4th Ave. South, Minneapolis, MN 55415 (612) 340-7000

LYTLE ASSOC. HEALTH CARE REV. DIVISION

101 Lang Blvd., P.O. Box 368
Grand Island, NY 14702 (716) 773-6626

MAIL HANDLERS BENEFIT PLAN

1390 Piccard Dr., Rockville, MD 20850 (301) 258-2751

MAJOR LEAGUE BASEBALL BENEFIT PLAN

1375 E. 9th St., Cleveland, OH 44114

MASSACHUSETTS MUTUAL LIFE INS. CO.

CORPORATE OFFICE

1295 State St., Springfield, MA 01111 (413) 788-8411
(800) 247-3455

GROUP PLAN CLAIMS

CA	17870 Castleton Street	(818) 810-3223
	City of Industry, CA 91748	(800) 247-3455
	1320 Willow Pass Road	
	Concord, CA 94520	(415) 798-3936
GA	315 W. Ponce de Leon Ave.	(404) 377-3446
	Decatur, GA 30030	(800) 333-2993
IL	4747 Lincoln Mall Drive	
	Matteson, IL 60443	(312) 747-3000
MA	1500 Main St., Springfield, MA 01115	(413) 788-8411
MN	8120 Penn Ave. South	
	Minneapolis, MN 55431	(612) 888-3135
NY	700 Veterans Highway	(516) 361-7202
	Hauppage, NY 11788	(800) 333-2770
OH	24650 Center Ridge Road	(216) 871-9692
	Westlake, OH 44145	(800) 437-2277
PA	212 Lakeside Drive	(215) 674-2025
	Horsham, PA 19044	(800) 333-2327
TX	12015 Park 35 Circle, Austin, TX 78753	(512) 835-9862

METROPOLITAN LIFE INSURANCE CO.

CORPORATE OFFICE

1 Madison Ave., New York, NY 10010 (212) 578-2211

PRIVATE PLAN CLAIMS

CA	425 Market, San Francisco, CA 94120	(415) 546-3300
FL	4100 Boy Scout Blvd., Tampa, FL 33607	(813) 870-8000
NY	1 Madison Ave., New York, NY 10010	(212) 578-2211
OK	P.O. Box 1350, Pittsburgh, PA 15230	(918) 252-8000

GROUP PLAN CAIMS

CA	200 Manchester Ave., Orange, CA 92668	(714) 939-2500
	425 Market, San Francisco, CO 94105	(415) 546-3201
CO	P.O. Box 2925, Englewood, CO 80150	(303) 770-6050
DE	P.O. Box 6017, Newark, DE 19714	(302) 368-2503
FL	4100 Boy Scout Blvd., Tampa, FL 33607	(813) 870-8298

GENERAL MOTORS

GA	1130 N. Chase Parkway	(404) 396-1050
	Marietta, GA 30067	(800) 241-9964
IL	P.O. Box 2002, Aurora, IL 60505	(605) 820-7500
MI	3031 W Grand Blvd., Detroit, MI 48202	(313) 873-7722
	1460 Walton Blvd., Rochester, MI 48063	(313) 652-2500
	P.O. Box 5147, Southfield, MI 48086	(313) 351-0040

GENERAL ELECTRIC

NY	P.O. Box 738, Glens Falls, NY 12801	(518) 584-5550
	2929 Express Dr. N.	
	Hauppauge, NY 11787	(516) 348-7200
	180 Schwenk Drive	(914) 339-4000
	Kingston, NY 12401	(800) 942-4640
	1 Madison Ave., Area 9-RZ	
	New York, NY 10010	(212) 578-6641
	P.O. Box 3025, Utica, NY 13504	(800) 552-3232
OH	9797 Springboro Pike	
	Dayton, OH 45470	(513) 859-6100
PA	Two Melon Bank Center	
	Pittsburgh, PA 15219	(412) 255-6200
RI	700 Quaker Lane, Warwick, RI 02887	(401) 827-2482
SC	P.O. Box 17000, Greenville, SC 29606	(803) 234-7115
TX	1701 Directors Blvd., Austin, TX 78744	(512) 462-3435
WA	P.O. Box 90487, Bellevue, WA 98002	(206) 828-6207

MID-AMERICA MUTUAL LIFE INSURANCE CO.
2021 E. Hennepin Ave.
Minneapolis, MN 55413 (612) 331-8370

MINNESOTA COMPREHENSIVE HEALTH ASSN.
P.O. Box 64566, St. Paul, MN 55164

MINNESOTA HEALTH NETWORK
2221 University Ave., S.E. #123
Minneapolis, MN 55414 (612) 623-2855

MINNESOTA LABORERS HEALTH & WELFARE FUND
7645 Metro Blvd., Minneapolis, MN 55435 (612) 835-7035

MINNESOTA MUTUAL LIFE INSURANCE CO.
400 N. Robert St., St. Paul, MN 55101 (612) 298-3500

MN INVESTORS LIFE INSURANCE CO.
2121 Precinct Line Rd., Hurst, TX 76053 (800) 527-2845

MONTGOMERY WARD LIFE INSURANCE CO.
P.O. Box 5008, North Suburban, IL 60198 (312) 882-0500

MUTUAL BENEFIT LIFE INSURANCE CO.
CORPORATE OFFICE
520 Broad St., Newark, NJ 07101 (201) 481-8000
(800) 821-7887

GROUP PLAN CLAIMS
CA 1455 Frazee Rd., San Diego, CA 92108 (619) 542-0600
(800) 451-4531
GA 2400 Lake Park Dr., Smyrna, GA 30080 (404) 433-2002
(800) 225-3893
IN P.O. Box 1916, Carmel, IN 46032 (317) 573-6700
(800) 283-3636
MN 6600 France Ave. South (612) 920-8055
Minneapolis, MN 55435 (800) 325-8385
MO P.O. Box 419876
Kansas City, MO 64141 (816) 474-2761
PA P.O. Box 5140, Allentown, PA 18105 (215) 437-4844
TX 1700 Alma, Plano, TX 75075 (214) 881-9092
(800) 444-6254

MUTUAL LIFE INSURANCE CO. OF NEW YORK
CORPORATE OFFICE
1740 Broadway, New York, NY 10019 (212) 708-2000
PRIVATE PLAN CLAIMS
1 Mony Plaza, Syracuse, NY 13221 (315) 477-3319
GROUP PLAN CLAIMS - EMPLOYEE BENEFITS OF AMERICA
KY 1717 Dixie Hwy., Ft. Wright, KY 41011 (800) 354-9845
TX 8144 Walnut Hill Lane (214) 691-8106
Dallas, TX 75231 (800) 223-8530
WA Box C3500, Federal Way, WA 98003 (206) 838-9500
(800) 426-8439

MUTUAL OF OMAHA INSURANCE CO.
CORPORATE OFFICE
Mutual of Omaha Plaza, Omaha, NE 68175 (402) 342-7600
PRIVATE PLAN CLAIMS
J.E. JONES
DC 1666 Connecticut Ave., N.W.
Washington, DC 20009 (202) 797-6700
S.B. STOTTRUP
IL P.O. Box 670, Decatur, IL 62525 (217) 429-5495
A.H. HARRIS
IL P.O. Box 4630, Springfield, IL 62708 (217) 528-3434
GEORGE RICHARDSON
NC P.O. Box 670
Winston-Salem, NC 27102 (919) 723-1854
J.G. BROCK
NY 1900 Genessee St., Utica, NY 13502 (315) 732-6191
S.W. DIVISION OFFICE
TX P.O. Box 3189, Dallas, TX 75221 (214) 630-4100
GROUP PLAN CLAIMS
DC 1666 Connecticut Ave. N.W.
Washington, DC 20009 (202) 797-6700
MD 2094 Gaither Road (301) 963-0080
Rockville, MD 20850 (800) 638-8432
MN 1606 S. Highway 100 (612) 546-7006
Minneapolis, MN 55440 (800) 328-0055
NE S-3-OGCPC Mutual of Omaha Plaza
Omaha, NE 68175 (402) 978-2775
TX P.O. Box 590, Addison, TX 75001 (214) 363-7465
(800) 334-4661
WA 1750 112 Ave. N.E. (206) 454-2230
Bellevue, WA 98124 (800) 426-8039

MUTUAL SERVICE LIFE INSURANCE CO.
P.O. Box 64035, St. Paul, MN 55164 (612) 631-7000

NATIONWIDE LIFE INSURANCE CO.
CORPORATE FOFICE
1 Nationwide Plaza, Columbus, OH 43216 (614) 249-6809
GROUP PLAN CLAIMS
CO 9110 E. Nichols Ave.
Englewood, CO 80112 (800) 824-9486
GA P.O. Box 88154, Atlanta, GA 30356 (800) 824-9486
MD 2500 Riva Road S.E.
Anapolis, MD 21401 (800) 824-6948
NC 4401 Creedmore Rd., Raleigh, NC 27622 (800) 824-9486
OH P.O. Box 2399, Columbus, OH 43216 (614) 249-7111
TX 600 Six Flags Dr., Arlington, TX 76011 (800) 824-9486

NEW ENGLAND MUTUAL LIFE INSURANCE CO.
CORPORATE OFFICE
501 Boylston St., Boston, MA 02117 (617) 266-3700
GROUP PLAN CLAIMS
3500 West 80th St., Bloomington, MN 55431 (800) 227-5688

NEW YORK LIFE INSURANCE CO.
CORPORATE OFFICE
51 Madison Ave.,New York, NY 10010 (212) 576-7000
GROUP PLAN CLAIMS
CA P.O. Box 6924, Ventura, CA 93006 (805) 658-8696
P.O. Box 4010, Concord, CA 94524 (415) 682-4141
DC 1818 H St. NW, Washington, DC 20433 (202) 676-1473

NEW YORK LIFE INSURANCE CO. (continued)

GA	P.O. Box 105095, Atlanta, GA 30348	(404) 448-5944
KY	P.O. Box 1090, Louisville, KY 40202	(502) 582-2671
LA	P.O. Box 1249, Gretna, LA 70054	(504) 361-1009
MD	6301 Ivy Lane, Greenbelt, MD 20770	(301) 441-8070
MI	P.O. Box 1700, Detroit, MI 48231	(313) 967-2680
MN	P.O. Box 500, Minneapolis, MN 55440	(612) 884-4041
MO	P.O. Box 1007, St. Ann, MO 63074	(314) 298-7155
NJ	P.O. Box 4000, Freehold, NJ 07728	(201) 431-3131
PA	180 Sheree Blvd., Exton, PA 19341	(215) 524-1255
TX	P.O. Box 660239, Dallas, TX 75266	(214) 692-8165

NORTH AMERICAN LIFE & CASUALTY CO.

	1750 Hennepin Avenue	(612) 347-6500
	Minneapolis, Mn 55403	(800) 328-5600

NORTH CENTRAL LIFE INSURANCE CO.

	P.O. Box 43149, St. Paul, MN 55164	(612) 227-8000

NORTHWESTERN NATIONAL LIFE INS. CO.

	CORPORATE OFFICE	
	20 Washington Ave. South	(612) 372-5458
	Minneapolis, MN 55440	(800) 328-1601
	PRIVATE PLAN CLAIMS	
	P.O. Box 1258, Minneapolis, MN 55440	(612) 372-5458
	GROUP PLAN CLAIMS	
CA	730 Fairmont Ave., Glendale, CA 91203	(818) 246-5705
		(800) 824-4286
CA	80 Grand Ave., Oakland, CA 94612	(415) 444-7988
GA	5500 Oakbrook Parkway	
	Norcross, GA 30093	(404) 938-8844
IL	25 E. Washington, Chicago, IL 60602	(312) 346-0090
LA	4640 S. Carrollton Ave.	
	New Orleans, LA 70119	(504) 525-0626
MA	3 Center Plaza, Boston, MA 02108	(617) 523-0921
MD	5900 Princess Garden Parkway	
	Lanham, MD 20706	(301) 459-1660
MN	P.O. Box 1258, Minneapolis, MN 55472	(612) 372-5458
	P.O. Box 1195, Mineapolis, MN 55440	(612) 372-5458
TX	14651 Dallas Parkway	(214) 387-9028
	Dallas, TX 75240	(800) 233-4737

OXFORD LIFE INSURANCE CO.

	2721 North Central Ave., Phoenix, AZ 85004	(602) 263-6666

PACIFIC MUTUAL LIFE INSURANCE CO.

	CORPORATE FFICE	
	700 Newport Center Drive	(714) 640-3011
	Newport each, CA 92663	(800) 854-9347
	GROUP PLAN CAIMS	
AZ	234 N. Central Ave.	(602) 254-5311
	Phoenix, AZ 85004	(800) 854-5395
CA	601 S. Glenoaks Blvd.	(818) 845-6100
	Burbank, CA 91501	(800) 327-2814
GA	P.O. Box 105090	(404) 396-7700
	Atlanta, GA 30348	(800) 322-8384
KY	1717 Dixie Hwy., Ft. Wright, KY 41011	(606) 331-9300
WA	P.O. Box C-3500	(206) 838-9500
	Federal Way, WA 98003	(800) 426-8439

PHILADELPHIA AMERICAN LIFE INS. CO.

	CORPORATE FOFICE	
	1233 West Loop South, Houston, TX 77027	(713) 871-4674
	GROUP PLAN CLAIMS	
PA	P.O. Box 1563	(215) 337-7333
	King of Prussia, PA 19406	(800) 634-5688
TX	P.O. Box 2465, Houston, TX 77252	(713) 871-4674
		(800) 333-9413
	100 N. 6th St., Waco, TX 76701	(817) 752-9704
		(800) 333-9202
WI	4625 Washington Ave.	
	Racine, WI 53405	(414) 632-1555

PHOENIX MUTUAL LIFE INSURANCE CO.

	CORPORATE OFFICE	
	1 American Row, Hartford, CT 06115	(203) 275-5000
	GROUP PLAN CLAIMS	
	P.O. Box 677, Greenfield, MA 01301	(413) 774-3151

PRINCIPAL MUTUAL LIFE INSURANCE CO.
(Principal Financial Group)

	CORPORATE OFFICE	
	711 High St., Des Moines, IA 50309	(800) 247-4695)
	GROUP PLAN CLAIMS	
AZ	10210 N. 25th Ave., Phoenix, AZ 85021	(800) 323-8722
CA	2505 W. Shaw Ave., Fresno, CA 93710	(800) 523-5938
	5030 Camino de la Siesta	
	San Diego, CA 92108	(800) 654-1268
	1310 Redwood Way	
	Petaluma, CA 94952	(800) 227-1408
	275 E. Hillcrest Drive	(805) 373-0400
	Thousand oaks, CA 91360	(800) 323-3686
CO	400 S. Colorado Blvd.	
	Denver, CO 80222	(800) 424-1875
CT	530 Presten Ave., Meriden, CT 06450	(800) 331-0745
FL	P.O. Box 31298, Tampa, FL 33631	(800) 443-5810
GA	100 Galleria Pkwy., Atlanta, GA 30339	(800) 247-3531
IA	4050 River Ridge Dr., N.E.	(319) 395-7987
	Cedar Rapids, IA 52402	(800) 223-8030
	711 High St., Des Moines, IA 50309	(800) 262-3283
IL	1245 Corporate Blvd., Aurora, IL 60504	(800) 826-1555
	1919 S. Highland Ave.	
	Lombard, IL 60148	(800) 874-0993
KS	10985 Cody, Overland Park, KS 66210	(800) 321-0123
MN	6160 Summit Dr.	
	Brooklyn Center, MN 55430	(612) 566-1211
MO	620 S. Glenstone Ave.	
	Springfield, MO 65802	(417) 869-0040
NE	330 North 117th St., Omaha, NE 68154	(800) 331-9443
OH	1105 Schrock Rd., Columbus, OH 43229	(800) 323-4646
OK	3817 N.W. Expressway	
	Oklahoma City, OK 73112	(800) 523-5665
OR	421 S.W. 6th Ave., Portland, OR 97204	(800) 826-0671
PA	111 Presidential Blvd.	
	Bala Cynwyd, PA 19004	(800) 522-1279
TX	8131 LBJ Freeway, Dallas, TX 75251	(800 367-1663
	10103 Fondren, Houston, TX 77096	(800) 331-1660
	2700 N.E. Loop 410	
	San Antonio, TX 78217	(800) 331-2557
WA	100 W. Harrison Plaza	
	Seattle, WA 98119	(800) 228-7398

PRINCIPAL MUTUAL LIFE INSURANCE CO. (continued)

WA	16300 Christensen Road Tukwila, WA 98188	(800) 826-9896
WI	2514 South 102nd Street West Allis, WI 53227	(800) 225-0702

PROVIDENT LIFE & ACCIDENT INSURANCE CO.

CORPORATE OFFICE

	1 Fountain Square, Chattanooga, TN 37402	(615) 755-1011 (800) 251-7420

PRIVATE PLAN CLAIMS

AL	3 Office Park Circle Birmingham, AL 35253	(205) 879-0320
AZ	3550 N.Central Ave., Phoenix, AZ 85012	(602) 264-9131
	4400 E Broadway, Tucson, AZ 85711	(602) 881-1717
AR	1 Inwood Circle, Little Rock, AR 72212	(501) 224-7781
CA	5200 Century Blvd. Los Angeles, CA 90045	(213) 568-1683
	3559 Wilshire Blvd. Los Angeles, CA 90010	(213) 386-0641
	4605 Lankershirm Blvd. N. Hollywood, CA 91602	(818) 506-1707
	P.O. Box 2226, Oakland, CA 94621	(415) 430-9871
	721 S. Parker St., Orange, CA 92668	(714) 835-5714
	8880 Rio San Diego Drive San Diego, CA 92108	(619) 298-4192
	1550 The Alameda, San Jose, CA 95126	(408) 275-9390
CO	7950 E. Prentice Ave. Englewood, CO 80111	(303) 770-5577
CT	2321 Witney Ave., Hamden, CT 06518	(203) 248-7173
FL	2655 Lejeune Road Coral Gables, FL 33114	(305) 443-1898
	4901 N.W. 17th Way Fort lauderdale, FL 33309	(305) 491-4902
	2901 Swamp Cabbage Ct. Fort Myers, FL 33901	(813) 286-7220
	7077 Bonneval Blvd. Jacksonville, FL 32216	(904) 281-0670
	3191 Maguire Blvd., Orlando, FL 32803	(305) 894-2751
	5401 W Kennedy Blvd. Tampa, FL 33609	(813) 286-7220
	1551 Forum Place West Palm beach, FL 33401	(407) 478-1504
GA	1 Piedmont Center, Atlanta, GA 30363	(404) 261-1930
IL	39 S. LaSalle St., Chicago, IL 60603	(312) 346-4146
	1 Mid America Plaza Oakbrook Terrace, IL 60181	(312) 954-7170
	200 N.E. Adams St., Peoria, IL 61602	(309) 673-3278
	9501 West Devon, Rosemont, IL 60018	(312) 825-3103
IN	11555 N. Meridian,a Carmel, IN 46032	(317) 843-5735
KY	106 W. Vine St., Lexington, KY 40507	(606) 255-0975
	714 Meidinger Tower Louisville, KY 40202	(502) 587-0511
LA	1515 Poydras, New Orleans, LA 70112	(504) 581-5781
	333 Texas, Shreveport, LA 71101	(318) 222-0636
MA	31 Milk St., Boston, MA 02109	(617) 426-0125
MD	10 E. Baltimore, Baltimore, MD 21202	(301) 659-0222
MI	161 Ottawa N.W. Grand Rapids, MI 49503	(616) 459-9584
MI	26261 Evergreen Road Southfield, MI 48076	(313) 827-2570
MN	822 Marquette, Minneapolis, MN 55402	(612) 339-8881
	1204-B Pioneer Building St. Paul, MN 55101	(612) 221-9885
MO	7101 College Blvd. Overland Park, KS 66210	(816) 421-4059
	8112 Maryland Ave. Clayton, MO 63105	(314) 725-9973
NC	6201 Fairview Rd., Charlotte, NC 28210	(704) 552-8485
	2840 Plaza Place., Raleigh, NC 27612	(919) 787-8152
NJ	60 Park Place, Newark, NJ 07102	(201) 623-9229
NY	1130 Liberty Bldg., Buffalo, NY 14202	(716) 853-3056
	805 Third Ave., New York, NY 10022	(212) 593-0160
	116 John St., New York, NY 10038	(212) 732-9585
	701 Westchester Ave. White Plains, NY 10604	(914) 686-0510
OH	1726 Young St., Cincinnati, OH 45210	(513) 241-1776
	1340 Depot St., Rocky River, OH 44116	(216) 331-1200
	471 E. Broad St., Columbus, OH 43215	(614) 228-6817
OK	4200 E. Skelly Blvd., Tulsa, OK 74135	(918) 494-2888
OR	4380 S.W. Macadam Ave., Portland, OR 97201	(503) 227-5190
PA	800 Corporate Circle Harrisburg, PA 17110	(717) 657-3314
	2 Penn Center Plaza Philadelphia, PA 19102	(215) 563-8406
	272 Alpha Dr., Pittsburgh, PA 15238	(412) 963-1200
SC	220 Executive Center Drive Columbia, SC 29210	(803) 731-9180
TN	100 W. Martin Luther King Blvd. Chattanooga, TN 37402	(615) 756-6631
	1111 Northshore Dr. Knoxville, TN 37919	(615) 584-0473
	889 Ridgelake Blvd. Memphis, TN 38119	(901) 682-4000
	P.O. Box 3410, Nashville, TN 37219	(615) 255-8481
TX	300 Littlefield Bldg., Austin, TX 78701	(512) 474-1471 (800) 252-3117
	301 Commerce St., Ft. Worth, TX 76102	(817) 332-7494
	1800 W. Loop S., Houston, TX 77027	(713) 626-0241
VA	7799 Leesburg Pike Falls Church, VA 22043	(703) 893-1885
	801 E. Main St., Richmond, VA 23219	(804) 225-8000
WA	2033 6th Ave., Seattle, WA 98121	(206) 441-8222 (800) 552-7788
WI	400 N. Executive Drive Milwaukee, WI 53005	(414) 797-8450

GROUP PLAN CLAIMS

AL	P.O. Box 20468, Birmingham, AL 35216	(205) 870-4111
AZ	1951 Camelback Road Phoenix, AZ 85015	(602) 433-6600
FL	5422 Bay Center Dr., Tampa, FL 33609	(813) 286-2658
GA	5600 Rosewell Rd., N.E. Atlanta, GA 30342	(404) 252-0973
IL	1055 W 175th St., Homewood, IL 60430	(312) 798-7664
MI	P.O. Box 30151, Lansing, MI 48909	(517) 882-6409
MO	55 W. Port Plaza, St. Louis, MO 63146	(314) 878-0585
NC	P.O. Box 2048, Gastonia, NC 28053	(704) 867-3831
OH	25 Merchant St., Cincinnati, H 45246	(513) 552-7000

SC 220 Executive Center Drive
Columbia, SC 29210 (803) 731-9180
P.O. Box 6185, Greenville, SC 29606 (803) 234-7790
TN 1241 Volunteer Parkway
Bristol, TN 37620 (615) 968-7541
401 Chestnut St., Chattanooga, TN 37402 (615) 755-4800
P.O. Box 171806, Memphis, TN 38187 (901) 761-1950
TX P.O. box 219700 , Houston, TX 77218 (713) 579-7768
UT P.O. Box 572488
Salt Lake City, UT 84157 (801) 485-6582
VA 1001 Boulders Parkway
Richmond, VA 23225 (804) 323-5111

PRUDENTIAL INSURANCE CO. OF AMERICA
CORPORATE OFFICE
P.O. Box 500, Mt. Arlington, NJ 07856 (800) 772-0118
PRIVATE PLAN CLAIMS
SMALL GROUP
FL P.O. ox 2229, Jacksonville, FL 32231 (904) 391-3902
MN P.O. Box 9402, Minneapolis, MN 55440 (612) 553-6111
CHIP
FL P.O. Box 2957, Jacksonville, FL 32232 (904) 391-3937
PRUMED
FL P.O. Box 2688, Jacksonville, FL 32232 (904) 391-4174
INDIV A&H
FL P.O. Box 4579, Jacksonville, FL 32231 (904) 391-4096
GROUP PLAN CLAIMS
CA P.O. Box 9101, Van Nuys, CA 91409 (818) 992-2000
(800) 433-3150
FL P.O. Box 2840, Jacksonville, FL 32231 (904) 391-4046
MN P.O. Box 1143, Minneapolis, MN 55440 (612) 349-1000
NJ 1 Campus Dr., Parsippany, NJ 07054 (201) 631-2000
PA P.O. Box 936, Horsham, PA 19044 (215) 443-2000

RICHARD REESE & ASSOCIATES
7645 Metro Blvd., Minneapolis, MN 55435

ROOFERS LOCAL 96
1449 Energy Park Drive, St. Paul, MN 55108

SECURITY LIFE INSURANCE CO. OF AMERICA
CORPORATE OFFICE
6681 Country Club Dr.
Minneapolis, MN 55427 (800) 328-4667
GROUP PLAN CLAIMS
P.O. Box 3680, Laguna Hills, CA 92654 (714) 380-0880
(800) 321-1632

SELECTIVE INSURANCE CO. OF AMERICA
CORPORATE OFFICE
40 Wantage Ave., ranchville, NJ 07890 (201) 948-3000
(800) 382-9209

GROUP PLAN CLAIMS
MD 201 International Circle (301) 771-6500
Hunt Valley, MD 21030 (800) 492-5546
NJ 645 Martinsville Road (201) 647-7444
Liberty Corner, NJ 07938 (800) 452-5743
6000 Midatlantic Drive (609) 778-3888
Mt. Laurel, NJ 08054 (800) 323-0391
P.O. Box 1001, Sparta, NJ 07871 (201) 579-4800
NJ 1 AAA Dr., CN07950 (609) 890-2200
Trenton, NJ 08650 (800) 792-9723
PA P.O. Box 3303, Lehigh Valley, PA 18001 (215) 481-9680
(800) 451-7465
P.O. Box 4648, Lancaster, PA 17604 (717) 291-1261
(800) 732-0049
VA P.O. Box 13325, Richmond, VA 23225 (804) 272-7568
(800) 572-7500

SENTRY DAIRYLAND INSURANCE CO.
P.O. Box 5000, Stevens Point, WI 55481

SENTRY LIFE INSURANCE CO.
P.O. Box 8888, Stevens Point, WI 55481 (800) 426-0460

ST. PAUL LIFE INSURANCE CO.
385 Washington St., St. Paul, MN 55110 (612) 221-7911

ST. PAUL WAREHOUSE EMPLOYEE WELFARE FUND
1721 Carroll, St. Paul, MN 55104

STATE FARM MUTUAL AUTOMOBILE INSURANCE CO.
CORPORATE OFFICE
One State Farm Plaza, Bloomington, IL 61701 (309) 766-2311
GROUP PLAN CLAIMS
1500 W. Highway 36, St. Paul, MN 55161 (612) 631-4000

SOUTHERN LIFE & HEALTH INSURANCE CO.
CORPORATE OFFICE
P.O. Box 671, Birmingham, AL 35201 (205) 933-1160
PRIVATE PLAN CAIMS
AL 2020 E. Three Notch St.
Andalusia, AL 36420 (205) 222-8418
3635 Commerce Ave.
Fairvield, AL 35064 (205) 788-3876
3753 Ross Clark Circle, N.W.
Dotham, AL 36303 (205) 792-2512
1550 Florence Blvd.
Florence, AL 35630 (205) 764-2731
3619 Forrest Ave., Gadsden, AL 35904 (205) 538-5393
2509 Commercial Park Drive
Mobile, AL 36606 (205) 479-1161
1825 Mt. Meigs Rd.
Montgomery, AL 36107 (205) 262-4648
1306 McCoy St., Opelika, AL 36801 (205) 745-4461
FL 50 S.W. 31st Avenue
Ft. Lauderdale, FL 33312 (305) 581-6520
2021 West 1st St., Ft. Myers, FL 33901 (813) 332-2519
631 Park St., Jacksonville, FL 32204 (904) 356-1288
1131 E. Lime St., Lakeland, FL 33801 (813) 682-0197
7650 W. Flagler St., Miami, FL 33144 (305) 264-0464
655 N.W. 119th St., N. Miami, FL 33168 (305) 685-6563
125 E. Silver Springs Blvd.
Ocala, FL 32670 (904) 622-4777
2601 E. Jefferson St., Orlando, FL 32803 (407) 894-3531
1330 Harrison Avenue
Panama City, FL 32401 (904) 763-8811

SOUTHERN LIFE & HEALTH INSURANCE CO. (continued)

FL	445 N. Pace Blvd., Pensacola, FL 32505	(904) 438-3373
	1252-B Blounstown Highway Tallahassee, FL 32304	(904) 575-4672
	4321 Bay-to-Bay Blvd. Tampa, FL 33629	(813) 837-6172
	2514-B S. Hopkins Ave. Titusville, FL 32780	(407) 267-2297
	1700 Upland Road West Palm Beach, FL 33401	(407) 686-8420
LA	608-A E. Prien Lake Road Lake Charles, LA 70605	(318) 478-4848
	3230 S. I-10 Service Road Metairie, LA 700001	(504) 832-7942
	211 N. Thomas Dr. Shreveport, LA 71107	(318) 425-8681
MS	181 Main St., Biloxi, MS 39530	(601) 436-3443
TX	2205 Berkeley Ave., Austin, TX 78745	(512) 447-1829
	3670 Boca Chica Blvd. Brownsville, TX 78520	(512) 541-4897
	2020 S. Texas Ave., Bryan, TX 77802	(409) 822-7695
	5725 S. Padre Island Drive Corpus Christi, TX 78412	(512) 993-6908
	1905 Avenue F, Del Rio, TX 78840	(512) 774-6140
	1602 W. Tyler, Harlingen, TX 78550	(512) 425-8057
	1722 Monarch Oaks Drive Houston, TX 77055	(713) 464-6209
	5301 Springfield Ave. Laredo, TX 78041	(512) 727-8799
	403 N. Main St., McAllen, TX 78501	(512) 682-9255
	2125 Center Hwy. Nacogdoches, TX 75961	(409) 564-7411
	3108 Hwy. 365, Nederlands, TX 77627	(409) 722-2020
	5431 Ingram Rd. San Antonio, TX 78228	(512) 435-8622
	714 Rayburn Dr. San Antonio, TX 78221	(512) 922-3221
	5118 San Pedro San Antonio, TX 78219	(512) 822-1443
	712 W. Front St., Tyler, TX 75702	(214) 597-6071
	302 Sam Houston Blvd. Victoria, TX 77901	(512) 575-0081
	1101 Washington Ave. Waco, TX 76701	(817) 756-4323
	GROUP PLAN CLAIMS	
AL	P.O. Box 671, Birmingham, AL 35201	(205) 933-1160

STATE FARM MUTUAL AUTOMOBILE INSURANCE CO.

	CORPORATE FOFICE	
	One State Farm Plaza Bloomington, IL 61710	(309) 766-2311
	GROUP PLAN CLAIMS	
AL	P.O. Box 2661, Birmingham, AL 35297	(205) 930-6000
AZ	1665 W. Alameda Dr. Tempe, AZ 85289	(602) 784-3000
CA	P.O. Box 25048, Santa Ana, CA 92799	(714) 241-1000
	P.O. Box 5047 Thousand Oaks, CA 91359	(818) 707-5858
CA	6400 State Farm Drive Rohnert Park, CA 94926	(707) 584-6011
CO	3001 8th Ave., Greeley, CO 80631	(303) 351-5000
FL	P.O. Box 45061, Jacksonville, FL 32232	(904) 443-4000
	3425 Lake Alfred Road Winter Haven, FL 33888	(813) 297-3000
IL	1 State Farm Plaza Bloomington, IL 61710	(309) 766-2311
IN	2550 Northwestern Avenue West Lafayette, IN 47906	(317) 463-8123
MD	800 Oak St., Frederick, MD 21701	(301) 696-6000
MI	410 East Dr., Marshall, MI 49069	(616) 781-4211
MN	1500 W. Hwy. 36., St. Paul, MN 55161	(612) 631-4000
MO	2000 I-70 Dr., S.W. Columbia, MO 65217	(314) 874-3276
NE	222 S. 84th St., Lincoln, NE 68510	(402) 486-5000
NJ	1750 Route 23, Wayne, NJ 07477	(201) 628-5200
OH	1440 Granville Rd., Newark, OH 43093	(614) 344-2161
OR	4600 25th Ave. N.E., Salem, OR 97313	(503) 463-3000
PA	One State Farm Drive Concordville, PA 19339	(215) 358-7000
TN	760 N.W. Broad St. Murfreesboro, TN 37131	(615) 898-6000
TX	9001 N. Interregional Hwy. Austin, TX 78753	(512) 834-5000
	P.O. ox 799100, Dallas, TX 75379	(214) 250-5000
VA	1550 State Farm Blvd. Charlottesville, VA 22909	(804) 972-3551

STATE MUTUAL LFE ASSURANCE CO. OF AMERICA

	CORPORATE OFFICE	
	440 Lincoln St., Worcester, MA 01605	(508) 852-1000 (800) 423-6011
	GROUP PLAN CLAIMS	
GA	2220 Parklake Dr., N.E. Atlanta, GA 30345	(404) 939-5500 (800) 241-9286
IL	1100 W. 31st St. Downers Grove, IL 60515	(312) 963-3580 (800) 323-3359
MA	472 Lincoln St., Worcester, MA 01605	(508) 853-3381 (800) 423-6011
MN	CC Systems, P.O. Box 64668 St. Paul MN 55164	(612) 456-5950
NJ	959 Route 46 East Parsippany, NJ 07054	(201) 263-2440 (800) 526-4530
PR	108 Ganges St., Rio Piedras, PR 00926	(809) 758-6412
TX	24 Greenway Plaza, Houston, TX 77046	(713) 622-3787 (800) 231-2041

TEAMSTERS LOCAL 544
2636 Portland Ave. So. #200
Minneapolis, MN 55407 (612) 871-5701

TEAMSTERS LOCAL 638
3001 University Ave. S.E., Minneapolis, MN 55415

TELEX GROUP HEALTH PLAN
9600 Aldrich Ave. S., Minneapolis, MN 55420

TIME INSURANCE COMPANY
515 West Wells, Milwaukee, WI 53201 (414) 271-3011a

TRAVELERS INSURANCE CO.
CORPORATE OFFICE
One Tower Square, Hartford, CT 06183 (203) 277-0111
PRIVATE PLAN CLAIMS
Two Riverview Sq., 7th Floor (203) 277-8594
East Hartford, CT 06108 (800) 243-8310
GROUP PLAN CLAIMS
AK 510 L St., Anchorage, AK 99501 (907) 276-8027
AR P.O. Box 51, Little Rock, AR 72203 (501) 664-5085
CA P.O. Box 5800, rea, CA 92622 (714) 671-8000
CT P.O. Box 2002, Hamden, CT 06536 (203) 281-2061
Two Riverview Square, 6th Floor (203) 277-4840
East Hartford, CT 06108 (800) 243-8786
FL P.O. Box 31766, Tampa, FL 33631 (813) 286-9290
GA P.O. Box 105312, Atlanta, GA 30348 (404) 393-7500
HI P.O. Box 1059, Honolulu, HI 96808 (808) 521-8331
IL P.O. Box 1200, Lansing, IL 60438 (312) 895-0700
P.O. Box 500, Matteson, IL 60443 (312) 747-9400
100 Park Plaza, Naperville, IL 60566 (312) 961-4340
KS P.O. Box 2919, Overland Pk., KS 66201 (913) 967-4000
MA 200 Rosewood Dr., Danvers, MA 01923 (508) 777-2800
MD P.O. Box 19081, Baltimore, MD 21284 (301) 494-7931
MI 82 Ionia Ave., N.W.
Grand Rapids, MI 49503 (616) 776-6800
MN 6465 Wayzata Blvd.
Minneapolis, MN 55440 (612) 340-4000
MO P.O. Box 66913, St. Louis, MO 63166 (314) 425-8500
NC P.O. Box 220374, Charlotte, NC 28222 (704) 364-9220
P.O. Box 7579, Greensboro, NC 27417 (919) 294-3840
NJ P.O. Box 700, 4 Echelon Plaza
Voorhees Township, NJ 08043 (609) 772-4350
NY P.O. Box 1917, Albany, NY 12201 (518) 454-4800
P.O. Box 23422, Rochester, NY 14692 (716) 262-5516
OH P.O. Box 16676, Columbus, H 43085 (614) 433-2000
PA One Chatham Center
Pittsburgh, PA 15219 (412) 456-4700
TX P.O. Box 660451, Dallas, TX 75266 (214) 470-8076
P.O. Box 4705, Houston, TX 77210 (713) 787-4142
UT P.O. Box 30956
Salt Lake City, UT 84130 (801) 561-6500
VA P.O. Box 26426, Richmond, VA 23260 (804) 254-4161
WA 1200 Sixth Ave., Seattle, WA 98101 (206) 464-3400
AT&T CLAIMS
NY P.O. Box 1916, Albany, NY 12201 (518) 454-4800
NYNEX CLAIMS
NY P.O. Box 1914, Albany, NY 12201 (518) 454-4902
RAILROAD CLAIMS
GA P.O. Box 2511, Augusta, GA 30999 (404) 736-4551
NY P.O. Box 313, Albany, NY 12201 (518) 454-4760
TX P.O. Box 660145, Dallas, TX 75266 (214) 470-8317
UT P.O. Box 30985
Salt Lake City, UT 84130 (801) 561-6500
RAILROAD MEDICARE
GA P.O. Box 10066, Augusta, GA 30999 (404) 736-4451
NY P.O. Box 395, Albany, NY 12201 (518) 459-8900
TX P.O. Box 665493, Dallas, TX 75265 (214) 840-4209
UT P.O. Box 30050
Salt Lake City, UT 84130 (801) 359-0227

TRAVELERS INSURANCE CO.
P.O. Box 36, Minneapolis, MN 55440

TWIN CITY IRON WORKERS HEALTH & WELFARE FUND
1449 Energy Park Drive, St. Paul, MN 55108 (612) 645-8641

TWIN CITY PIPE TRADES WELFARE FUND
700 Transfer Road, St. Paul, MN 55114 (612) 645-4540

WASHINGTON NATIONAL INSURANCE CO.
CORPORATE OFFICE
1630 Chicago Ave., Evanston, IL 60201 (312) 570-5500
GROUP PLAN CLAIMS
AZ 3003 N. Central Ave. (602) 230-0333
Phoenix, AZ 85012 (800) 228-2710
FL 1408 N. Westshore Blvd.
Tampa, FL 33607 (813) 289-8077
LA 3300 W. Espanade, Metairie, LA 70002 (504) 834-7897
(800) 558-9445
OR 421 S.W. 6th Ave., Portland, OR 97204 (503) 224-0404
TX 12941 IH45 North (713) 873-6150
Houston, TX 77060 (800) 223-5706
WI 120 Bishops Way, Brookfield, WI 53005 (414) 784-8082

WESTERN LIFE INSURANCE CO.
P.O. Box 64271, St. Paul, MN 55164 (612) 738-4000

WILSON McSHANE CORP.
2850 Metro Dr., Suite 404, Bloomington, MN 55420

WOODMAN ACCIDENT & LIFE
P.O. Box 82288, Lincoln, NE 68501

MAJOR HEALTH MAINTENANCE ORGANIZATIONS

ALABAMA

COMPLETE HEALTH OF ALABAMA
2160 Highland Ave., Birmingham, AL 35205 (205) 933-4607
AL: (800) 654-5507

HUMANA
500 Lowell Dr., Huntsville, AL 35801 (205) 534-8411
2368 Fair lane Dr., Bldg. E
Montgomery, AL 36116 (205) 277-1511

PARTNERS HEALTH PLAN
600 B eacon Parkway West
Birmingham, AL 35209 (205) 942-5787

PRIME HEALTH OF
124 S. University Blvd., Mobile, AL 36608 (205) 342-0022

ARIZONIA

CIGNA
11011 N. Black Canyon, Phoenix, AZ 85029 (602) 870-7515
P.O. Box 16873, Tucson, AZ 95732 (602) 571-6521

EQUICOR HEALTH PLAN
5353 N. 16th St., Tucson, AZ 85016 (602) 264-4057

HUMANA
P.O. Box 2180, Louisville, KY 40201 (602) 840-1851
(800) 367-7587

MAXICARE
5200 W. Century Blvd.
Los Angeles, CA 90045 (213) 649-7011

CALIFORNIA

BACAY PACIFIC HEALTH PLAN
P.O. Box 8619, San Francisco, CA 94128 (415) 952-2005
(800) 345-8882

CALIFORNIA CARE
P.O. Box 4089, Woodland Hills, CA 91365 (800) 825-1030

CARE AMERICA
20520 Nordhoff, Chatsworth, CA 91311 (818) 349-2273
(800) 227-3487

CHILDREN'S HOSPITAL HEALTH PLAN
1700 California St., San Francisco, CA 94109 (415) 563-7900
(800) 554-3110

CIGNA
9808 Scranton Rd., San Diego, CA 92121 (619) 457-5402
(800) 888-2091
P.O. Box 5029, Visalia, CA 93278 (818) 500-6673

FOUNDATION HEALTH PLAN
5030 El Camino Ave., Carmichel, CA 95608 (916) 456-7000

HEALTH PLAN OF AMERICA
2212 N. Winery, Fresno, CA 93703 (800) 888-9982
505 S. Main St., Orange, CA 92668 (800) 422-2669
3033 Cleveland Ave., Santa Rosa, CA 95403 (707) 544-2273
(800) 348-2070

KAISER
P.O. Box 12923, Oakland, CA 94604 (415) 987-3190
(800) 987-2772
5055 California Ave., Bakersfield, CA 93309 (805) 328-1682

LIFEGUARD HEALTH PLAN
P.O. Box 5506, San Jose, CA 95150 (408) 943-9400
(800) 462-6363

MAXICARE
1350 Bay Shore Hwy. (415) 375-8600
Burlingame, CA 94010 (800) 255-MAXI
P.O. Box 92983, Los Angeles, CA 90009 (213) 568-9000

NATIONAL MED
P.O. Box 5356, Modesto, CA 95352 (419) 586-5181
(800) 343-9031

PACIFICARE
P.O. Box 6006, Cypress, CA 90630 (714) 952-1121

PARTNERS HEALTH PLAN
P.O. Box 50037, San Bernadino, CA 92412 (800) 247-5727

PEAK HEALTH PLAN
2655 Camino Del Rio North (619) 299-6464
San Diego, CA 92108 (800) 543-7325

ST. JOSEPH OMNI HEALTH PLAN
11805 N. California, Stockton, CA 95204 (209) 466-6664

TRAVELERS
770 E. Shaw, Fresno, CA 93710 (209) 225-6667

UNITED HEALTH
3405 W. Imperial Hwy.
Inglewood, CA 90303 (213) 671-3465

VALUCARE
P.O. Box 25790, Fresno, CA 93729 (209) 435-8366

COLORADO

ALL AMERICAN ASSURANCE COMPANY
7887 East Belleview Avenue (303) 779-1111
Englewood, CO 80111 (800) 525-7662

COMPRECARE
Box 441170, Aurora, CO 80044 (303) 750-6200
(800) 877-9777

HMO
700 Broadway, Denver, CO 80203 (303) 831-4114
(800) 533-5643

KAISER
2045 Franklin St., Denver, CO 80205 (303) 861-3220
(800) 632-9700

PRUCARE
P.O. Box 378710, Denver, CO 80237 (303) 796-8788

QUAL-MED
216 Victoria Ave., Alamosa, CO 81101 (719) 598-0533

ROCKY MOUNTAIN
2784 Crossroads Blvd., Denver, CO 81506 (303) 243-7050

CONNECTICUT

CIGNA
2 Riverview Sq., East Hartford, CT 06108 (203) 289-6088
(800) 345-9458

COMMUNITY HEALTH CARE PLAN
221 Whitney Ave., New Haven, CT 06511 (203) 371-1527
(800) 345-9458

CONSTITUTION HEALTH NETWORK
321 Research Parkway, Meriden, CT 06511 (203) 721-7784
(800) 345-9458

KAISER
60 Washington St., Hartford, CT 06106 (203) 280-1200

PHYSICIANS HEALTH SERVICE
320 Post Rd., Darie, CT 06802 (800) 444-6222

US HEALTHCARE
P.O. Box 1125, Blue Bell, PA 19422 (800) 624-0756

DELAWARE

CIGNA
P.O. Box 15549, Wilmington, DE 19850 (800) 444-2150
P.O. Box 15538, Wilmington, DE 19850 (301) 720-5252

HMO
P.O. Box 1991, Wilmington, DE 19899

US HEALTHCARE
P.O. Box 1125, Blue Bell, PA 19422 (800) 624-0756

DISTRICT OF COLUMBIA

GEORGE WASHINGTON UNIV.
1901 Pennsylvania Ave., N.W. (202) 676-4103
Washinton, DC 20006 (800) 676-4114

HEALTH PLUS
6611 Keni, Riverdale, MD 20737 (301) 277-6520
(800) 635-3121

KAISER
4200 Wisconsin Ave., N.W. (202) 364-3400
Washington, DC 20016 (800) 368-5784

PRUCARE
P.O. Box 904, Harsham, PA 19044 (202) 775-4030
(800) 333-1862

FLORIDA

AV-MED
912 S.W. 2nd Ave., Gainesville, FL 32601 (904) 338-2193
(800) 237-1255
9424 Bay Meadows Rd., Maitland, FL 32751 (904) 733-8159
P.O. Box 569000, Miami, FL 33256 (813) 281-5650

CAPITAL HEALTH
2140 Centerville Pl., Tallahassee, FL 32308 (904) 386-3161

CARE FIRST
P.O. Box 19917, Jacksonville, FL 32245 (904) 730-2273

CIGNA
2502 Rocky Point, Tampa, FL 33014 (407) 660-0639
(800) 237-2904
15600 N.W. 57th Ave., Miami, FL 33014 (305) 826-6200
(800) 227-4918

COMPREHENSIVE AMERICAN CARE
2830 Douglas Rd., Coral Gables, FL 33134 (305) 441-1140

HEALTH ALLIANCE PLAN
1430 Lakeland Hill Blvd.
Lakeland, FL 33805 (813) 682-8100

HEALTH OPTIONS
8665 Baypine Rd., Gainesville, FL 32256 (800) 826-4727
2190 Airport Blvd., Pensacola, FL 32504 (904) 484-1500
3191 Maguire Blvd., Orlando, FL 32803 (407) 894-7200
3900 N.W. 79th Ave., Miami, FL 33166 (305) 591-9955
(800) 826-4727
1715 N.W. Shore Blvd., Tampa, FL 33607 (813) 289-8222

HUMANA
5401 W. Kennedy Blvd., Tampa, FL 33609 (813) 286-1960

MEDICAL CENTER HEALTH PLAN
P.O. Box 1103, Pensacola, FL 32524 (904) 484-4080
(800) 426-8072

METLIFE HCN
P.O. Box 5510, Maitland, FL 32794 (407) 660-1712
FL: (800) 331-5079
P.O. Box 945540, Maitland, FL 32794 (305) 771-6177

PRUCARE
841 Prudential Dr., Jacksonville, FL 32207 (904) 391-3415
P.O. Box 45064, Jacksonville, FL 32232 (305) 492-8244
2301 Lucien Wy., Maitland, FL 23751 (407) 875-6600
3450 W. Busch Blvd., Tampa, FL 33618 (813) 932-1977
FL: (800) 284-4302

GEORGIA

HMO
P.O. Box 3417, Atlanta, GA 30302 (404) 842-8400

KAISER
3355 Lenex Rd., Atlanta, GA 30326 (404) 233-0556

METLIFE HCN
P.O. Box 9455130, Maitland, FL 32794 (404) 396-2111

PARTNERS HEALTH PLAN
300 Interstate N. Parkway (404) 951-1255
Atlanta, GA 30339 (800) 543-2005

SAMARITAN HEALTH PLAN
5544 Oakdale, Smyrna, GA 30080 (404) 277-9000
(800) 962-6296

HAWAII

HMSA
P.O. Box 860, Honolulu, HI 96808 (808) 942-1111

ISLAND CARE
P.O. Box 37549, Honolulu, HI 96837 (808) 943-1127
(800) 345-9185

KAISER
711 Kapiolani Blvd., Honolulu, HI 96813 (808) 521-0803

IDAHO

GROUP HEALTH NORTHWEST
1111 Ironwood Ave.
Coeur d'Allene, ID 83814 (208) 746-2671

MEDICAL SERVICE BUREAU
P.O. Box 1106, Lewiston, ID 83501 (208) 746-2671
(800) 632-2022

NATIONAL HOSPITAL ASSOCIATION
P.O. Box 5695, Portland, OR 97208 (503) 222-0399
(800) 327-3388

PEAK HEALTH PLAN
300 Mallard Dr., Boise, ID 83706 (208) 343-3330
(800) 999-6119

ILLINOIS

ANCHOR
33 E. Congress St., Chicago, IL 60605 (312) 247-3440

BLACKHAWK HEALTH ASSURANCE PLAN
630 E. Jefferson, Rockford, IL 61107 (815) 963-5431

CARLECARE
602 N. University, Urbana, IL 61801 (217) 337-8100
(800) 431-2273

CHICAGO HMO LTD.
540 North Lasalle, Chicago, IL 60610 (312) 751-4460
(800) 826-9400

CIGNA
P.O. Box 3010, Burbonnais, IL 60914 (314) 726-7860
1700 Higgins Rd., Des Plaines, IL 60018 (312) 699-5700
8182 Maryland Ave., St. Louis, MO 64105 (314) 726-7860
(800) 527-6636

DREYER HMO
2111 Plum St., Aurora, IL 60506 (312) 859-0400
(800) 759-9199

FOUNDATION HEALTH PLAN
2600 Farragut, Springfield, IL 62704 (217) 787-2002

GROUP HEALTH
11475 Old Cabin Rd.
Creve Coeur, MO 63141 (314) 993-6494

HEALTH CHICAGO
950 Warrenville Rd., Lisle, IL 60532 (312) 964-2700

HMO
P.O. Box 49219, Colorado Springs, CO 80919 (800) 325-7498
233 N. Michigan Ave., Chicago, IL 50501 (800) 325-7498

MAXICARE
P.O. Box 2942, Chicago, IL 60690 (312) 786-9830

METLIFE HCN
1375 E. Woodfield Rd., Schamburg, IL 60173 (312) 619-2240
8670 Big Ben, Webster Groves, MO 63119 (314) 469-3300

MICHAEL REESE
2555 S. King Dr., Chicago, IL 60616 (312) 808-3801

PRUCARE
Box 24549, St. Louis, MO 63141 (312) 390-3249
Box 27379, St. Louis, MO 53141 (314) 542-2121
(800) 627-0687

UNION HEALTH SERVICE
1634 W. Polk, Chicago, IL 60612 (312) 829-4224
(800) 468-4968

INDIANA

ARNETT HMO
3768 Rome Dr., Lafayette, IN 15805 (317) 448-8200

CIGNA
1700 Higgins, Lake County, IL 60018 (312) 699-5700

PARTNERS HEALTH PLAN
100 E. Wing St., South Bend, IN 46624 (219) 233-4677

WELBORN HMO
19 N.W. 14th St., Evansville, IN 47708 (812) 425-3939

IOWA

CARE CHOICES
401 Terra Center, Sioux City, IA 51101 (712) 252-2344

SHARE
2700 Wes Town Parkway,
Des Moines, IA 60265 (515) 225-1234

KANSAS

CIGNA
9225 Indian Creek Pkwy. (913) 451-9388
Overland Park, KS 66210 (800) 289-9380

EQUICOR HEALTH PLAN
P.O. Box 780008, Wichita, KS 67278 (316) 681-1152
(800) 678-1152

FAMILY HEALTH PLAN
Box 348, Wichita, KS 67114 (316) 283-5880

HMO
P.O. Box 110, Topeka, KS 66601 (800) 432-0216

KAISER
6900 Squibb Rd., Mission, KS 66202 (913) 384-9090

PRIME HEALTH OF
5799 Broadmoor, Mission, KS 66202 (913) 722-5000

KENTUCKY

HEALTHWISE
489 E. Main St., Lexington, KY 40507 (606) 259-1771
(800) 367-7587

HMO
P.O. Box 23297, Louisville, KY 40223 (800) 452-4195

HUMANA
9300 Shelleyville Rd., Louisville, KY 40222 (502) 423-1355
(800) 448-0222
P.O. Box 2180, Louisville, KY 40201 (502) 423-1355
(800) 367-7587
2180 Louisville, Louisville, KY 40201 (606) 263-1400
(800) 267-7587

METLIFE HCN
10509 Timberwood Circle
Louisville, KY 40223 (502) 423-3931
P.O. Box 22010, Louisville, KY 40222 (502) 423-3931
(800) 633-7683

LOUISIANA

CIGNA
8550 United Plaza Blvd. (504) 922-4260
Baton Rouge, LA 70809 (800) 445-1471

MAXICARE
3850 N. Causeway Blvd.
Metairie, LA 70002 (504) 836-2022

MARYLAND

CHESAPEAKE HEALTH PLAN
814 Light St., Baltimore, MD 21230 (301) 539-8622

CIGNA
9700 Pauxent Woods Dr.
Columbia, MD 21046 (301) 621-8490

COLUMBIA MEDICAL PLAN
2 Knoll North Dr., Columbia, MD 21045 (301) 997-8500
(800) 262-PLAN

FREE STATE HEALTH PLAN
16026 York Rd., Cockeysville, MD 21030 (301) 683-0100

HEALTH PLUS
4301 Connecticut Ave., Riverdale, MD 20737 (301) 277-6520

JOHNS HOPKINS HEALTH PLAN
2214 Hartford Rd., Baltimore, MD 21214 (301) 444-5400

M.D. IPA
4 Taft Court, Rockville, MD 20850 (301) 294-5110
(800) 638-8898

MASSACHUSETTS

BERKSHIRE HEALTH PLAN
395 South St., Pittsfield, MA 01201 (413) 499-4009

CENTRAL MA
100 Front St., Springfield, MA 01608 (508) 754-1870
(800) 922-8380

CIGNA
1350 Main St., Springfield, MA 01103 (413) 733-1177

COMMUNITY HEALTH PLAN
59 Interstate Drive (413) 736-8376
W. Springfield, MA 06511 (800) 344-5682

FALLON COMMUNITY HEALTH PLAN
100 Parkwell St., W. Boylston, MA 01583 (508) 835-2550
(800) 635-1221

HEALTH NEW ENGLAND
66 Industry Ave., Springfield, MA 01104 (413) 787-4000
(800) 631-5005

HEALTHWAY MEDICAL PLAN
1 Pearl St., Brockton, MA 02401 (508) 586-3600

KAISER
P.O. Box 862, Amherst, MA 01004 (413) 256-0151
(800) 847-7526

LAHEY CLINIC
41 Mall Rd., Burlington, MA 01805 (617) 273-8556
(800) 448-2992

MEDICAL WEST CHP
444 Montgomery St., Chickopee, MA 01020 (413) 594-3111

MONTACHUSETT HEALTH PLAN
285 Central St., Leominster, MA 01453 (508) 534-4100

PILGRIM HEALTH CARE
10 Eccord Executive Dr. (617) 871-3950
Norwell, MA 02061 (800) 742-8326

PRUCARE
P.O. Box 4001, Iselin, NJ 08830 (800) 422-7399

TUFTS ASSOCIATED HEALTH PLAN
400-2 Toten Pond Rd., Waltham, MA 02254 (617) 466-9410
(800) 462-0224

WESTERN MA HEALTH PLAN
1 Round House Plaza (413) 586-9161
Northampton, MA 01060 (800) 227-7759

MICHIGAN

BLUE CARE NETWORK
4200 Fashion Sq. Blvd., Saginaw, MI 48603 (517) 791-3222
(800) 322-8336
1769 S. Garfield Ave., Trevor City, MI 49684 (616) 941-7823
(800) 548-3035
3624 S. West Nedge, Kalamazoo, MI 49008 (616) 965-2442
(800) 638-0884
611 Cascade West Parkway (616) 957-5057
Grand Rapids, MI 49546 (800) 968-2583
1403 S. Creyts Rd., Lansing, MI 48917 (517) 322-8022
(800) 828-8123

CARE CHOICES
723 Kenmore S.E., Grand Rapids, MI 49546 (616) 957-1100

COMPREHENSIVE AMERICAN CARE
6500 John C. Lodge, Detroit, MI 48202 (313) 875-9355
(800) 875-2814

HEALTH ALLIANCE PLAN
2850 W. Grand Blvd., Detroit, MI 48202 (313) 872-8100
(800) 873-7526

HEALTH PLUS
2050 S. Linden Rd., Flint, MI 48501 (313) 230-2222
(800) 332-9161

M-CARE
3601 Plymouth Rd., Ann Arbor, MI 48105 (313) 747-8700

SELECTCARE
363 W. Big Beaver, Troy, MI 48084 (313) 680-1100

TOTAL HEALTH CARE
2500 Fisher Bldg., Detroit, MI 48202 (313) 871-2000

MINNESOTA

BLUE CROSS & BLUE SHIELD
AWARE, TRIPLE GOLD, BLUE PLUE, HMO-MN
P.O. Box 64560
St. Paul, MN 55164 (800) 382-2000

FAMILY HEALTH PLAN
3800 W. 80th St., Suite 1450
Bloomington, MN 55431 (612) 896-1200

GROUP HEALTH
2829 University Ave., S.E.
Minneapolis, MN 55414 (612) 623-8400

MEDCENTERS ALT PLANS
P.O. ox 36100
Minneapolis, MN 55435 (612) 897-1640

MINNESOTA (continued)

METROPOLITAN HEALTH PLAN
822 S. 3rd St.
Minneapolis, MN 55415 (612) 347-2121

PHYSICIANS HEALTH PLAN
P.O. Box 1555, Minneapolis, MN 55440 (612) 936-1821
(800) 328-9609

PREFERRED ONE
100 Landmark Towers
345 St. Peter
St. Paul, MN 55102 (612) 293-3650

SHAKE
3600 W. 80 Bloomington Freeway (612) 936-6000
Minneapolis, MN 55431 (800) 637-4273

VIRGINIA MASON HEALTH PLAN
P.O. Box 36151, Minneapolis, MN 55435 (206) 467-8565
(800) 338-4123

WESTERN RESERVE HEALTH PLAN
P.O. Box 36217, Minneapolis, MN 55435 (216) 486-0152

MISSOURI

PRIME HEALTH OF
6801 E. 117th, Kansas City, MO 64134 (913) 722-5000

PRUCARE
1300 E. 104th St., Kansas City, MO 64131 (816) 941-4500
(800) 526-2953

Box 24549, St. Louis, MO 53141 (314) 542-2121

SANUS HEALTH PLAN
P.O. Box 37380, St. Louis, MO 63141 (314) 434-6114
(800) 627-0687

NEBRASKA

PRINCIPAL HEALTH CARE
10810 Farnham, Omaha, NE 68454 (402) 333-1720
(800) 288-3343

SHARE HEALTH PLAN
302 South 36th St., Omaha, NE 68131 (402) 345-5500

NEVADA

HEALTH PLAN
P.O. Box 15645, Las Vegas, NV 15645 (702) 646-8350

NEW HAMPSHIRE

HARVARD COMMUNITY
P.O. Box 516, Boston, MA 02215 (617) 739-6161

HEALTHSOURCE
P.O. Box 2041, Concord, NH 03302 (800) 531-3121

KAISER
P.O. Box 862, Amherst, MA 01004 (413) 256-0151
(800) 847-7526

NEW JERSEY

CIGNA
P.O. Box 15191, Wilmington, DE 19850 (800) 444-2150

COMED
3 Stewart Crt., Denville, NJ 07834 (201) 361-8808
(800) GO-COMED

HIP
100 Norizon Center, Robbinsville, NJ 08691 (800) 635-0441

MAXICARE
6 N. Chestnut St., Philadelphia, PA 19106 (215) 238-9880

MEDIGROUP
750 Allentown-Robinsville Rd.
Robbinsville, NJ 08691 (609) 259-5965

METLIFE HCN
P.O. Box 6100, Utica, NY 13504 (800) 872-1080

OMNICARE
1138 E. Chestnut Ave., Vineland, NJ 08360 (609) 696-8004

RUTGERS COMMUNITY HEALTH PLAN
1 World's Fair Dr., Somerset, NJ 08873 (201) 560-9898

US HEALTHCARE
P.O. Box 1109, Blue Bell, PA 19422 (800) 323-9930
P.O. Box 1125, Blue Bell, PA 19422 (215) 542-8900
(800) 624-0756

NEW MEXICO

HEALTH PLAN
6100 Uptown Blvd., N.E. (505) 889-8800
Albuquerque, NM 87110 (800) 548-3724

HEALTH PLUS
P.O. Box 27489, Albuquerque, NM 97125 (505) 823-0000
(800) 356-2884

LOVELACE HEALTH PLAN
P.O. Box 27107, Albuquerque, NM 87125 (505) 262-7363
(800) 432-9123

NEW YORK

BLUE CHOICE
150 E. Main St., Rochester, NY 14646 (716) 454-4810
(800) 462-6826

CHOICECARE
50 Charles Lindburgh Blvd.
Uniondale, NY 11553 (516) 222-1460

COMMUNITY HEALTH PLAN
1201 Troy-Schenectady Rd.
Latdom, NY 12110 (518) 783-1864

FOUNDATION HEALTH PLAN
8278 Willett Pkwy., Baldwinsville, NY 13127 (315) 638-2133

GHI HEALTH PLAN
330 W. 42nd St., New York, NY 10036 (212) 760-6425

GROUP HEALTH
150 E. Main St., Rochester, NY 14646 (716) 238-4510
(800) 847-1200

HEALTH CARE PLAN
900 Guarantee, Buffalo, NY 14202 (716) 847-1480
(800) 847-1480

NEW YORK (continued)

INDEPENDENT HEALTH ASSOCIATION
777 International Dr., Buffalo, NY 14221 (716) 631-5392
(800) 247-1466

INDEPENDENT PREPAID HEALTH PLAN
8278 Willett Pkwy.
Baldwinville, NY 13027 (315) 638-4900

KAISER
711 S. Broadway, White Plains, NY 10601 (914) 682-7720

METLIFE HCN
P.O. Box 6100, Utica, NY 13504 (800) 872-1080

MIDHUDSON HEALTH PLAN
P.O. Box 3786, Kingston, NY 12401 (914) 338-0202
(800) 443-4711

MOHAWK VALLEY HEALT PLAN
108 Union St., Schenectady, NY 1205 (518) 370-4793
80 Washington St., Poughkeepsie, NY 12601 (914) 473-1762
(800) 777-4793

PREFERRED CARE
259 Monroe Ave., Rochester, NY 14607 (716) 325-3920

PREPAID HEALTH PLAN
8278 Willett Pkwy., Baldwinville, NY 13027 (315) 638-2133

PRUCARE
P.O. Box 4004, Iselin, NJ 08830 (800) 422-7399

TRAVELERS
620 Erie Blvd., Syracuse, NY 13204 (315) 479-6677

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HEALTHOHIO
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4150 Belden Village St., N.W.
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P.O. Box 470475, Tulsa, OK 74147 (405) 942-2200
(800) 345-8310
Box 470540, Tulsa, OK 74147 (918) 624-4664
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OR: (800) 468-9529

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2701 N.W. Vaughn St., Portland, OR 97210 (503) 280-2000

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1300 Postoak Blvd., Houston, TX 77056 (713) 623-0244

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San Antonio, TX 78229 (512) 696-2010
3301 South Alameda
Corpus Christi, TX 78411 (512) 854-8955

KAISER
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TX: (800) 637-0171

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401 2nd Ave S., Seattle, WA 98104 (206) 326-4645
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Documentation

INTRODUCTION

The concept of documentation is not new to the educational system. Teachers and special education personnel have always been required to complete documentation in one form or another. Documenting a specific session with a student or outlining progress on a session-to-session basis, however, is novel. Districts that choose to implement a third party reimbursement system will need to be aware of the payor documentation requirements outlined in this chapter.

It is extremely threatening to providers, who have a current set of standards and routines, to be told to conform to a new set of requirements. At a minimum, providers of education-based related services now complete an Individual Education Plan (IEP) and fulfill any individual district documentation requirements. These individual district requirements may include lesson plans, assessments and anecdotal notes, but requirements vary by individual school setting and discipline. Regardless of current school district requirements, however, providers of related services will need to incorporate additional parameters into their current system in order to meet the requirements of third party payors when implementing a new reimbursement system.

The range of additional documentation requirements varies by state, reimbursement source, the professional providing the services and state licensure requirements. It is to the benefit of the district, though, to develop, standardize and adopt one complete system of documentation regardless of the payor source or the ability to collect third party reimbursement. It is very confusing to the professionals providing services to learn and implement multiple systems based on different reimbursement sources or on the lack of available funding.

Most indemnity carriers and HMOs outline the minimal documentation they require for reimbursement. Some insurers require physician orders for initiation and continuation of treatment, for example, but do not require standardized and formal daily note or progress note documentation. It is not uncommon for them to request working papers and notes regarding the services provided, however. Providers who are able to produce standardized

documentation regarding the services provided and the progress obtained are more likely to receive reimbursement.

The documentation requirements for reimbursement by Medicaid are routinely more stringent than those for other third party payors. Although many requirements regarding documentation within each state are based on federal regulations, different state Medicaid agencies require different documentation. The parameters of documentation required will be influenced by state licensure laws and state legislation and rule requirements even though federal regulations currently outline minimal documentation requirements for certain types of providers (hospitals, nursing homes and outpatient clinics, for example). School districts should review the documentation requirements of their state Medicaid agency and adopt standardized procedures that include those Medicaid requirements. It is worth noting, however, that some states currently paying for related services to school districts have adopted less stringent requirements for the school-based provider than are currently required of providers certified by the HCFA and state departments of health.

The development of standardized procedures should be based upon thorough knowledge of both the state Medicaid requirements and individual district requirements and procedures. It is crucial to incorporate both methods in order to minimize paperwork and avoid allocating extra staff time to the completion of documentation for the purposes of third party reimbursement. The integration of the two methods can be done within the current individual education plan process, as will be demonstrated later in this chapter.

It is not solely for the purposes of reimbursement that developing and implementing a standardized documentation system for all providers of related services is important. It is necessary to ensure a method of accountability. The documentation of treatment and progress on a regular basis is one way to measure the success, maintenance or failure of intervention. Adequate and consistent documentation is one form of quality assurance. On an ever increasing basis, school districts and education personnel are being required to prove that intervention with students is appropriate.

Documentation in fact serves all of the following purposes:

1. It provides a serial legal record of the student's condition and the course of therapeutic intervention from initiation of the IEP through the time of discharge.
2. It serves as an information source for students and their families.
3. It facilitates communication among the professionals involved with the student.
4. It furnishes data for use in treatment, education, research and reimbursement.
5. It provides a method for documenting quality assurance.

There are two major components to documentation: those that focus on the individual student and the service provided to him or her and those that focus on reimbursement of service provided. Student related documentation includes evaluation or assessment reports, individual education plans, daily notes, consultation reports, progress summaries and

discharge summaries. Third party reimbursement access forms include student identification forms, insurance information forms, referral authorization, parental consent forms, physician orders, billing logs or time sheets and data flow and tracking forms. Samples of these forms are found in the appendices at the end of this chapter.

STUDENT RELATED DOCUMENTATION

All documentation is an integral part of the treatment record, otherwise known—within the health care industry—as the clinical record. Each student referred for evaluation or treatment must have a treatment record maintained as a permanent file. Treatment files must be maintained for the same period of time as all other student records (the legal requirements vary by state). Treatment records can be part of the student's file maintained within the building where services are provided or within the district's educational services center. The treatment record should contain signed originals of all documentation.

All treatment records should be clear, concise, accurate and legible. Statements should be written in an objective manner, and the information provided should clearly distinguish facts from opinion. The treatment record is a legal document, which can be reviewed by students or their families and requested in legal matters. Treatment records should be written with correct grammar and spelling. Abbreviations should be limited to those standardized by the professional discipline and accepted by the school district. (See the standardized list of abbreviations provided in appendix 8-A at the end of this chapter for reference.)

Fundamental Documentation Elements

The following fundamental elements should be present in all student related documentation.

1. The student's full name and identification number should appear on each page of documentation.

2. The data should be stated in a month, day and year format for each entry (01/01/91).

3. The type of documentation (such as speech-language pathology, audiology, physical therapy or occupational therapy) and the school and/or district name should be identified on all title pages.

4. The signature of the professional providing services should include at least first and last name and professional designation (for example, Jane Doe, OTR; Mary Smith, RPT; Nancy Jones, SLP). It is acceptable to use a professional designation abbreviation rather than writing out the professional's title.

5. The signature of the person documenting the services should be entered directly at the end of the progress note without any space left following the body of the note.

6. A countersignature by a professional should be entered on documentation completed by students and therapy assistants when required by law or payor source.

7. All documentation should comply with confidentiality standards.

8. Only accepted terminology, as defined by the professional's discipline and the school district, should be used.

9. Only approved abbreviations should be used.

10. Errors should be corrected by drawing a single line through the error and making any necessary change. The correction should be initialed. The use of correction fluid or erasures is not acceptable.

Types of Documentation

The following types of student related documentation are required within the health care industry.

- Assessment or Evaluation Reports
- Treatment Plan with Goals and Objectives
- Daily Treatment Notes
- Progress Summaries
- Consultation Reports
- Discharge Summary

Neither the scope of information necessary nor the formats to be used are mandated. It is the responsibility of the professional providing the services to produce documentation that is meaningful and sufficient to summarize the services provided and the progress attained.

If the professionals providing the services view documentation as an added duty from which they see no benefit, the task becomes mundane and rote. Professionals who allow this to happen may not have learned to use documentation procedures to their advantage when working with students.

School districts should provide workshops regarding health related documentation procedures to staff. Workshops need to include pragmatic sessions for practice and designate professional staff to work individually with staff to implement new systems. Professionals should use the daily notes to develop progress summaries.

The progress summaries, when completed on a regular basis, can provide current information regarding the course of treatment and the progress of the student. When consistent progress is measured and recorded, even on the smallest goal or task, and is reviewed regularly, the course of treatment can be modified more frequently. This then allows the professional to be more current with goals and objectives and to introduce new objectives and procedures on a regular basis. My experience indicates that if completing documentation is seen as drudgery, then the service provided to students becomes boring and unimaginative and does not meet the students' needs. Professionals who combine appropriate treatment and good documentation provide the best services and enjoy their work.

The forms used for supplying documentation and reports within the health care industry vary tremendously. When developing forms, several practical matters should be considered. First, it is important to standardize the forms, having them either printed or computer generated, so as to ease the work of the professional. Prototypes that are easily completed

and printed using an NCR form produce a ready copy and can be completed quickly by hand. Second, most forms should be developed in triplicate so that the original can be filed in the treatment record, a copy can be maintained by the professional, and another copy is available for parents or other professionals.

Third, it is not important that documentation forms be filled out on a typewriter by the professional. Staff should be encouraged to hand write daily notes and progress summaries so as to save time and staff costs, unless the forms are produced on computers that are available to the professionals on a regular basis. In that case, all district professionals can easily update progress summaries directly on the computerized forms, without repeating such rote data as name, identification numbers, and long-term IEP goals.

Using staff who will implement a new documentation system to help develop the forms and create new documentation software provides them with ownership in the new endeavor. They are not then likely to feel that a new system was thrust upon them without giving them the chance to consider alternatives and to provide input.

While it is strongly recommended that providers and school districts (using their own staff) develop formats that best meet their individual needs, this chapter provides a series of documentation forms as examples (See appendices 8-B to 8-M). Each form has pros and cons.

Assessment or evaluation reports. Assessment or evaluation reports can be more or less formalized documents. In fact, many school districts merely include the assessment data on their individual education plans. Others produce reports that contain information from the individuals in all disciplines who assessed the student (such as speech-language pathology and occupational and physical therapy). An evaluation summary can be attached to the student's IEP or stand alone as a document to be reviewed by the professionals involved. The assessment report should include all pertinent data regarding the student.

Identifying Information and History:

Include the student's name, chronological age, medical and treatment diagnosis, educational concerns, date of evaluation, referral source, significant developmental/ medical/social history and a summary of any previous treatment.

Summary and Analysis of Findings:

State the name and type of evaluation, date administered and results. State facts in an objective manner. The analysis of findings should include measurable data and should define the student's strengths and weaknesses. Subjective data and observational information are also appropriate. Additional sources of data or previous evaluation results should be included if they help form the total assessment of the student. Formulate findings and list treatment needs, indicating whether treatment is warranted.

Goals and objectives. The treatment plan, which can either be included in the assessment report or be part of the student's IEP, should contain appropriate goals and outline the short-term objectives projected as necessary for reaching those goals. Treatment methods should be outlined, including the type, amount and frequency of treatment. A statement regarding the anticipated time necessary to achieve objectives should be included as should a summary indicating the student's potential functional outcome.

Physician Authorization:

If a signature line for the physician to indicate agreement with the recommended course of treatment is included on an evaluation summary, the summary can then serve to provide physician authorization. Once the form is then forwarded to the physician for review and signature, the signature constitutes physician authorization for the treatment record.

Daily treatment notes. The daily note outlines briefly the date, type, frequency, duration and scope of professional services provided and serves as a record for the services provided. Providers often use the daily note to document student responses. The daily note should also be used to document absences from treatment, consultations with families and other professionals and any unusual circumstances that may influence the student's intervention plan.

Progress summaries. The progress summary provides a current summary of the student's progress on the goals and objectives outlined and an opportunity for the development of new objectives when necessary (See appendices 8-F through 8-J). The progress summary is routinely completed every 60 days, but the Medicaid laws for physician recertification that require the completion of the progress summary vary by state and by service provider.

Federal regulations dictate physician certification requirements for different provider entities. Home health agencies, for example, are required to have a physician certify the patient's plan of care every 60 days, but Medicare rehabilitation agencies are required to obtain physician certification of the patient's plan of care every 30 days. Some states have allowed annual or quarterly recertifications for school district providers. A few states require certification by a physician every 30 days.

Progress summaries should include appropriate identification data, medical diagnosis, contraindications to treatment, a description of the functional level of the student, the goals and objectives delineated for the period covered, a description of the student's progress toward the objectives as outlined and additional goals and objectives as appropriate. Summaries can also include a description of the student's physical and behavioral responses to treatment (which may influence progress toward objectives), changes in anticipated time frames with regard to objectives, attendance and participation within the treatment plan by the student, statements regarding the student's missing sessions, student related communications and information regarding carryover programs.

Consultation reports. Consultation reports can either take the form of a progress summary or be a new form created exclusively for students receiving services on a less consistent and/or less frequent basis (See appendix 8-K). Services rendered once per month by a physical therapist to a student may be considered a consultative program. The therapist provides services to the student with modeling and demonstration provided to the classroom staff. The student receives direct intervention on a more frequent basis by the classroom staff, and the program is monitored and reviewed by the physical therapist. The consultation report form allows for more narrative data than a standard progress summary but should contain the same type of information.

Discharge summary. The discharge summary should contain appropriate identification information, medical diagnosis, a description of the functional level of the student, the goals and objectives outlined during the course of treatment, a description of progress and the reason for discharge (See appendices 8-L and 8-M). The summary should be clearly labeled as a Discharge Summary and include any follow-up recommendations or programs. A discharge summary can include a written carryover program to be followed after discharge and should state any recommendations pertaining to the student's future needs. Referrals to other health care providers or community agencies should be delineated. A discharge summary should only be completed when a student is discharged from intervention.

A discharge summary should not be completed when the student will not receive services during the summer or during a vacation break. The progress summary should be used to indicate that the student will not receive services during this period and should indicate that services will resume when school reconvenes. For this purpose, a statement such as "Direct intervention will continue in September when (student's name) returns to school" or "The next progress summary will be sent when programming resumes in the fall" will suffice. Emphasizing the current goals and objectives as outlined and noting the continuation of services following the break in a school year constitutes adequate documentation.

REIMBURSEMENT DOCUMENTATION FORMS

School districts that provide services and seek third party reimbursement will need to design forms to incorporate the data elements necessary to complete an invoice. The following forms will need to be developed, or current IEP forms amended, to meet third party reimbursement access needs.

- Parental Information and Consent Form
- Student Identification and Information Form
- Billing Log
- Physician Authorization

Parental Information and Consent Form

The school district should develop a letter to parents that describes the district's rationale for requesting access to the family's health insurance coverage (See appendices 8-N and 8-O). Rationale should include legal authority, but the letter must also include a statement that informs parents of their right to deny access to their health insurance.

Parental consent forms should reiterate the district's authority to access third party payor sources and should request parental authorization for access of the family's health insurance (See appendix 8-P). The form must clearly communicate to parents that the health related services deemed necessary through the IEP process must be provided even if the parents refuse access to the third party payor.

The form should guarantee parents that all coinsurance and deductibles are the responsibility of the school district. School districts can indicate that the payment of coinsurance and deductibles by the district provides less out-of-pocket expense to families. The form must also tell families that the use of insurance benefits must not deplete the family's policy benefits. This statement helps to clarify the school's obligation to provide a "free and

appropriate" education as required in P.L. 94-142. A statement indicating the maximum dollar amounts the school district will bill per year could provide psychological safeguards to families. The district should also indicate that if recovery of insurance benefits by the district depletes lifetime maximums that are needed at a later time, the district will repay the insured the amount collected.

Student Identification and Information Form

The student identification and information form provides information about the student and his or her family's third party reimbursement source (See appendices 8-Q and 8-R). The student identification form can be routinely completed on every student regardless of access of third party reimbursement, but the information can be requested either as part of the enrollment procedures or following permission by parents to access reimbursement. The form should be completed by the student's family and should include at least the following information:

1. Student's name, address, telephone number and date of birth.
2. The student's physician's name, address, telephone number and any numbers associated with the provider, if available.
3. The student's insurance information, including carrier name, address, group and policy number, the name of the subscriber or insured who is the policy holder (usually the parent), the address of the insured (if different from the student) and the insured's relationship to the student.
4. The student's Medicaid number, if applicable.
5. The name of the person who completed the form.

It is helpful for families to provide medical diagnostic information regarding the student. A space for a diagnosis or an ICD-9 number can be added to this form. Parents of children with handicaps often know their child's medical diagnosis.

Billing Log

A billing log or reporting form can include the minimal amount of data adequate to prepare an invoice or it can be expanded to include daily progress notes (See appendices 8-S through 8-U). It is recommended that the document be a carbonless form developed in duplicate or triplicate. The original can then be sent to the billing office and copies retained for the clinical record and the service provider.

This form should include at least the following information:

1. The location where services were provided (name of school or building number).
2. The period of coverage for the services provided (month, year).
3. The type of services provided (physical therapy, occupational therapy, speech-language pathology, audiology, psychological, physician or nursing).

4. The name of the student and the identification number assigned the student by the district.

5. The name and title of the service provider.

6. The payor source (name and type).

7. A description of the services provided. The description of services provided relates to the procedure code. (See chapter 5 for the description that accompanies each procedure code.)

8. The procedure code that matches the description of service (such as HCPCS or CPT). (See chapter 5.)

9. The units or time periods of services provided, or both.

10. The ICD-9 codes in relation to the services provided and the procedure codes used on this billing or reporting form. (See chapter 5.)

11. The authorization or reauthorization numbers and the period of coverage that pertain to the period of service, when applicable.

The payor source and ICD-9 information are routinely available from the Student Identification and Information forms, as described in section B above and appendices 8-Q and 8-R.

Various sample forms for billing or reporting purposes are provided in appendices 8-S, 8-T and 8-U. The following comments are provided regarding the forms in appendixes 8-S and 8-T to highlight differences that may influence the design of a form.

Some agencies currently providing medical services use a billing log that contains all the procedure code possibilities, making it very easy for different service providers to circle an erroneous code. It is recommended that the form designed by school district providers require the service provider to write in the procedure code that best describes the intervention provided.

Form 8-S: This form provides the information necessary to complete an invoice for one student and provides space for documentation of daily progress and services. This form can be combined with a supplemental progress note form (Form 8-S(a)) as a second page. The billing or reporting form will then include a daily progress log for each service provided and submitted for reimbursement. This form is completed for each client and provided to the billing office on a regular basis.

The advantage of this form is that the billing office has current information and daily documentation regarding the services provided when third party payor sources request information. It is not unusual for a payor to request copies of daily progress notes and progress summaries prior to payment. Medicaid may review documentation when completing postpayment reviews. Forms can be completed on a bimonthly basis, providing data input on a more frequent basis for billing purposes.

Form 8-T: This form provides for reporting on multiple clients and does not provide progress or daily documentation information. It assumes that the billing office has correct information regarding payor source, ICD-9 codes, and authorization or reauthorization data. This form covers one week of service.

The advantage of this form is that it allows the service provider to report on multiple students on one form. The form relates to one week of services and provides information to the billing office on a weekly basis.

It is important for school districts to develop a form that provides the billing office with adequate information for invoice preparation and payment collection. The ease of preparation and time necessary for form completion should also be considered. The service provider should not be required to complete unnecessary or complicated forms. The easier and less complex the forms, the greater amount of time the provider has to offer services to students.

Physician Authorization

The initial physician authorization for evaluation and/or treatment can be obtained by requesting the physician to sign a form created specifically for this purpose or it can be obtained by telephone (See appendix 8-V). If the physician is contacted by appropriate school personnel and permission is obtained by verbal orders to assess and/or treat the student, written documentation must still be obtained from the physician following verbal orders. To document verbal orders, a telephone order form completed by district staff and sent to the physician for signature can provide a written record of the date the services were authorized. The physician orders should be maintained in the treatment record.

Physician authorization for treatment can also be obtained by adding a line to the bottom of the evaluation or assessment report completed by the professional staff and forwarded to the student's attending physician for signature and dating. In addition, physician authorization can be obtained by adding a line for physician signature to the IEP form. If the IEP is then forwarded to the physician for signature, dating and return, it can serve as authorization of the services outlined on the IEP for reimbursement purposes. Physician reauthorization for continuing intervention can be obtained using the progress summary form or the consultation report.

School districts initiating their third party reimbursement system may not be comfortable contacting physicians by telephone or sending complex IEP reports without explanation. Appendix 8-W provides a sample of a "Physician Introduction Letter," which suggests how a district might provide information and legal reference for physicians when requesting written permission for evaluation and treatment.

Appendix 8-X provides a written form to accompany a physician information letter when a district is requesting physician permission to assess individual students. The sample provided allows the school district to request permission to assess by individual or multiple disciplines. The use of this form would allow a district to request permission from the student's physician to assess for many types of services.

THIRD PARTY REIMBURSEMENT SYSTEM FORMS

School districts will need to develop organized systems for tracking the student and reimbursement related forms necessary to implement a third party reimbursement system. Appendices 8-Y, 8-Z, and 8-AA provide three sample forms for tracking some of the necessary third party reimbursement documentation.

Appendix 8-Y provides a format for tracking, on a monthly basis, multiple student progress summaries. Appendix 8-Z provides a format for tracking physician authorization and progress summaries for all services that pertain to an individual student. Appendix 8-AA provides a format for tracking physician authorization, HMO prior authorization and completion of an initial progress summary for multiple students. These tracking formats can also easily be established within a computerized data base system.

INTEGRATION OF HEALTH RELATED DOCUMENTATION REQUIREMENTS WITH CURRENT EDUCATION PRACTICES

School districts are very familiar with special education documentation requirements. Public Law 94-142 requires that school districts document the special education service delivery process beginning with referral and concluding with termination of services and follow-up. School district providers are familiar with completing all the necessary due process forms. The documentation requirements of a third party reimbursement process are very similar to those of the special education documentation process.

Both the third party reimbursement process and the special education process begin with a referral. Identification and background information are collected as a part of the referral process with both systems, but the third party reimbursement process requires additional physician authorization and insurance billing information. Still, the components of the health care documentation system parallel the components of the education documentation system.

The special education process contains the due process requirement of obtaining parental permission prior to assessment. Parental permission is also inherent with the third party reimbursement process and should be formally documented. Once parental permission and physician referral are obtained, an assessment can be completed. The intent of the assessment components in both systems is to gather pertinent background information, administer evaluations that will facilitate the medical and educational diagnosis, and formulate the needs of the student. When physician authorization is obtained prior to assessment, the assessment can be considered a billable service.

When the needs of the student are identified, both systems require documentation to determine eligibility for services. The special education system requires that students meet eligibility requirements outlined by the school district. The eligibility criteria vary by district and by state. Once eligibility is determined, the individual education plan is formulated by a multidisciplinary team and the parents. The plan must be approved by the parents prior to implementation. The eligibility of part (or all) of the IEP's elements to qualify as health related services is influenced by (1) the student's diagnosis, (2) physician authorization and (3) the elements' ability to meet the third party payor's definition of

medical necessity. The definition of medical necessity varies by payor source. The physician's certification of the treatment plan alone may, however, qualify the service as medically necessary.

Once eligibility for services is determined and documented, both systems begin the service delivery process. The individual education plan is the formal document that is required by the special education process to describe the recommended services. The initial treatment plan is the formal document used by the health care system to describe the recommended health care services. Both plans contain clearly defined goals and objectives and activities or methods for meeting the student's needs. Both plans indicate the type, amount and frequency of services and treatment to be provided. Both plans indicate the anticipated outcomes as they relate to the objectives, and both specify timelines.

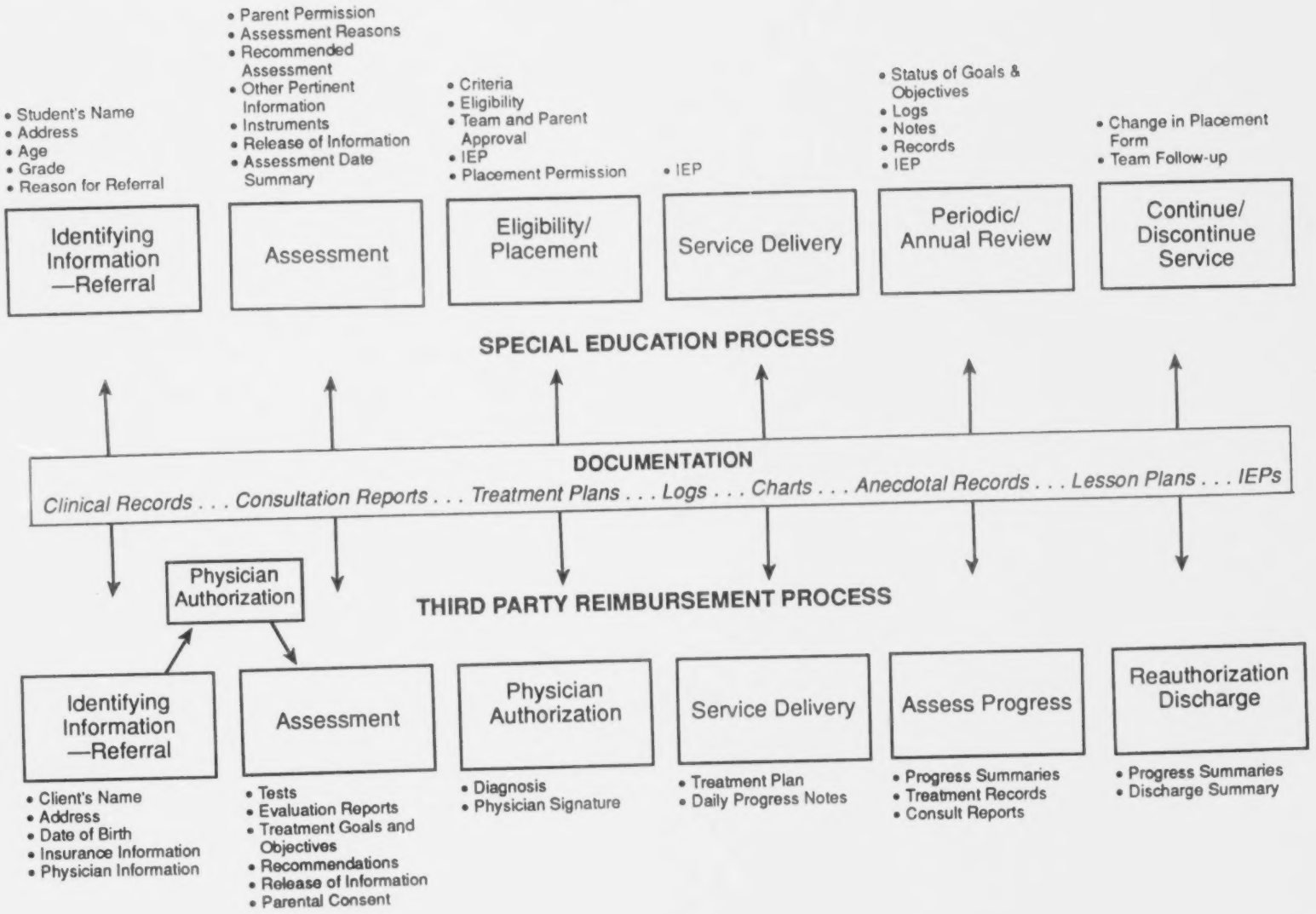
The continual assessment of a student's progress is a component of both the special education and third party reimbursement systems. Both systems require that progress be monitored on a periodic basis. The third party reimbursement system typically requires that daily notes be completed, and progress summaries maintained and reviewed by the student's attending physician on a periodic schedule. (This schedule varies by payor source requirements.) The special education system typically utilizes anecdotal records, logs and teacher notes to document progress, but does not require completion of daily or weekly progress notes. It merely requires two formal meetings per year—one periodic and one annual—to document a special education student's progress. Progress reviews may be held more frequently, of course, but this is not required.

The final step in both systems is the determination of when services should be continued as outlined, modified or discontinued. The third party reimbursement system requires physician reauthorization for continuing or modifying services. When services are no longer necessary, a discharge summary must be developed and sent to the physician for certification. Within the special education system the determination of whether or not a service should continue is outlined in an IEP. The IEP can be modified during the periodic and annual review meetings. If changes in a student's IEP are deemed necessary during the multidisciplinary meeting, appropriate changes are made. If the student has met all the goals and objectives outlined on the IEP and special education services are no longer required, services are discontinued.

Figure 8-1 clearly demonstrates the similarities of the third party reimbursement and special education processes and integrates the two systems. As the figure demonstrates, both systems require completion of identifying information and a referral, as well as individual student assessment and development of goals and objectives. Implementation of a third party reimbursement system will require districts to obtain more identifying and insurance information and incorporate the physician authorization process into current systems. Completion of student assessments and development of goals and objectives will not change. As Figure 8-1 outlines, districts currently complete progress assessments and formal discharge or continuation procedures on different formats and timelines but the process is similar.

Figure 8-2 provides a visual integration of third party reimbursement into the education process. The documentation necessary for access of reimbursement is boxed in asterisks.

Figure 8-1

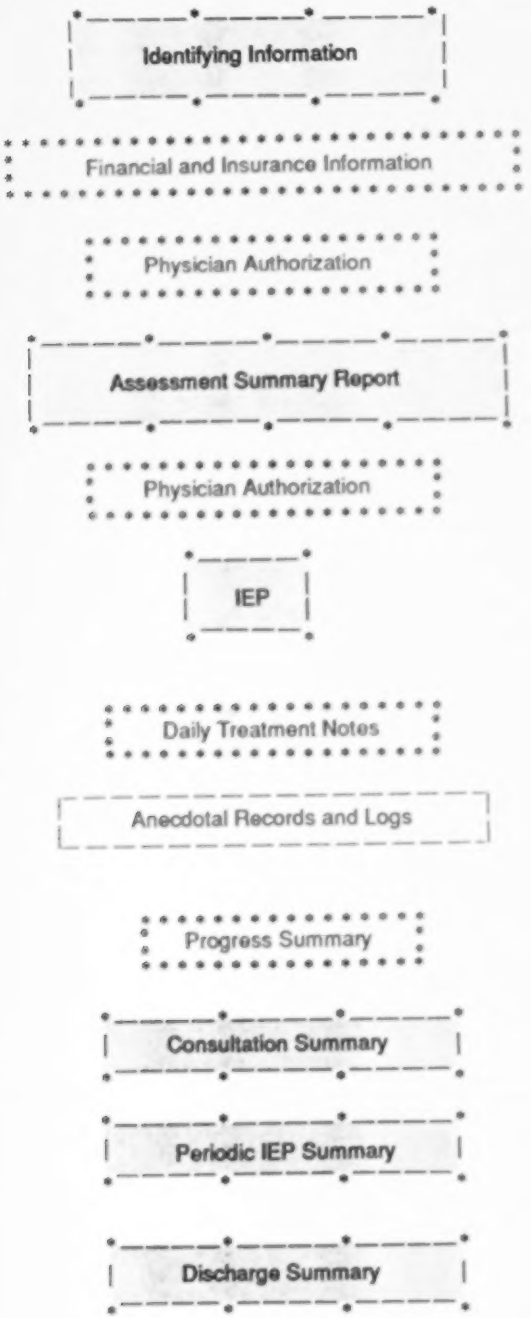

• Student's Name
• Address
• Age
• Grade
• Reason for Referral
Identifying Information —Referral
• Parent Permission
• Assessment Reasons
• Recommended Assessment
• Other Pertinent Information
• Instruments
• Release of Information
• Assessment Date Summary
Assessment
• Criteria
• Eligibility
• Team and Parent Approval
• IEP
• Placement Permission
Eligibility/ Placement
• IEP
Service Delivery
• Status of Goals & Objectives
• Logs
• Notes
• Records
• IEP
Periodic/ Annual Review
• Change in Placement Form
• Team Follow-up
Continue/ Discontinue Service
SPECIAL EDUCATION PROCESS
DOCUMENTATION
Clinical Records . . . Consultation Reports . . . Treatment Plans . . . Logs . . . Charts . . . Anecdotal Records . . . Lesson Plans . . . IEPs
Physician Authorization
THIRD PARTY REIMBURSEMENT PROCESS
Identifying Information —Referral
• Client's Name
• Address
• Date of Birth
• Insurance Information
• Physician Information
Assessment
• Tests
• Evaluation Reports
• Treatment Goals and Objectives
• Recommendations
• Release of Information
• Parental Consent
Physician Authorization
• Diagnosis
• Physician Signature
Service Delivery
• Treatment Plan
• Daily Progress Notes
Assess Progress
• Progress Summaries
• Treatment Records
• Consult Reports
Reauthorization Discharge
• Progress Summaries
• Discharge Summary

The documentation necessary for completion of the education process is boxed in dashes. The documentation necessary for both processes is boxed in *-----*. Both the similarities among the systems and the easy integration of one system into the other are evident in this figure.

When a school district begins to implement a third party reimbursement system, the district must integrate the documentation requirements of third party payors and the special education system. It is not necessary or wise to develop separate systems. The development of parallel documentation systems would only perpetuate the myth that health related services provided within the school district setting are dramatically different from the health related services provided within other settings. It is crucial to the implementation of a third party reimbursement system to establish such an integrated documentation system. An integrated system will create less confusion for professionals providing services and for the parents of students with handicapping conditions.

The forms referenced in chapter 8 provide a multitude of options for each district to consider. The district's operating procedures and the number and degree of standardized forms currently in place will influence the district's development of an integrated process. There is no one correct parental consent form, progress summary or daily note. Districts will need to go through the process of trial and error to establish the forms and procedures that meet the needs of their students and the professionals who serve them.

Figure 8-2
Integration of Third Party Reimbursement Forms



Key:
* * * * * * * * = documentation necessary for access of reimbursement
— — — — — = documentation necessary for completion of the education process
———— = documentation currently necessary for both processes

Appendix 8-A

ABBREVIATIONS

Abn ..... Abnormal
ADL ..... Activities of Daily Living
Admin .... Administration
A.M. ..... Morning
Amt ..... Amount
AUD ..... Audiology
BC/BS .... Blue Cross Blue Shiled
Bid ..... Twice Daily
CCC ..... Certificate of Clinical Competence
CFY ..... Clinical Fellowship Year
CMV ..... Cytomegalovirus
CNS ..... Central nervous system
COTA ..... Certified Occupational Therapy Assistant
d ..... Day
d/c ..... Discharge
Dept. ..... Department
DHS ..... Department of Human Services
DOB ..... Date of Birth
Dr. ..... Doctor
Dx ..... Diagnosis
eval ..... Evaluation
exam ..... Examination
F ..... Female
FM ..... Fine motor
Freq ..... Frequently
ft. ..... Foot, feet
GM ..... Gross motor
h or hr. .... Hour
HMO ..... Health Maintenance Organization
ht. ..... Height
Hx ..... History of
in. ..... Inch
(L) or Lt ... Left
lb. ..... Pound (weight)
Liq ..... Liquid
LPN ..... Licensed Practical Nurse
LTG ..... Long term goals
M ..... Male
MA ..... Medical Assistance (Medicaid) Mental Age
Meds ..... Medications
mg ..... milligram
MSW ..... Masters of Social Work
Mtg ..... Meeting
NDT ..... Neurodevelopmental therapy
Neg ..... Negative
O2 ..... Oxygen
Occ ..... Occasionally
od ..... Every day
O.T. ..... Occupational Therpy
OTR ..... Occupational Therapist, Registered
oz. ..... ounce
Peds ..... Pediatrics
P.M. ..... Afternoon
PN ..... Progress Note
POC ..... Plan of Care
PRN ..... As occasion requires, when arises
psych ..... Psychiatric
pt ..... Patient
PT ..... Physical Therapy, Physical Therapist
PTA ..... Physical Therapy Assistant
q ..... Every
QA ..... Quality Assurance
qd ..... Every day
qh ..... Every hour
q2h ..... Every 2 hours
qid ..... Four times a day
qod ..... Every other day
(R) ..... Right
ROM ..... Range of motion
rot ..... Rotation
RPT ..... Registered Physical Therapist
RN ..... Registered Nurse
Rx ..... Treatment
s ..... Without
S.I. ..... Sensory integration
SLP ..... Speech-Language Pathologist
STG ..... Short term goals
tid ..... Three times daily
TQ ..... Telephone Order
Tx ..... Treatment
vs. ..... Versus
wk ..... Week
WNL ..... Within normal limits
wt. ..... Weight
yr. (s) ..... Year (s)

Appendix 8-B

Daily Treatment Notes 1

Student Name: _____ School: _____

Period of Coverage: From: _____ To: _____

Treatment Objectives	Date																													
Provider's Initials																														
Total Units																														

Date	Progress Notes	Service Provider

☐ PT ☐ OT ☐ SLP
☐ AUD ☐ PSYC ☐ Other

_____ _____
Service Provider Date

Appendix 8-C

Daily Treatment Notes 2

(Include Procedure Code/Minutes and Units of Service, Signature/Title, and Date for Each)

Student_____ Stud. #_____ School_____

Procedure Code/Minutes & Units of Service Service Provider Signature/Title Date

Procedure Code/Minutes & Units of Service Service Provider Signature/Title Date

Procedure Code/Minutes & Units of Service Service Provider Signature/Title Date

Procedure Code/Minutes & Units of Service Service Provider Signature/Title Date

Appendix 8-D

Daily Treatment Note 3

Student Name: _____

Date: _____

☐ PT ☐ OT ☐ SLP ☐ PSY ☐ AUD

Period of Coverage _____

_____
Signature of Service Provider

Appendix 8-E

Daily Treatment Note 4

	PROGRESS NOTES	
DATE		SIGNATURE

Appendix 8-F Progress Summary 1

Student Name:_____ Period of Coverage:_____

Student #_____ School:_____

Birthdate:_____ Discipline_____

Physician:_____

Treatment Diagnosis:_____

Contraindications to Treatment:

Functional Level of Student

Recommended Treatment Length/Frequency:

Long Term Goals (as reflected on IEP):

Short Term Objectives: Description of Progress
(Progress Rating: C=Change; M=Met; PM=Partially Met)

Recommendations:

This student continues in my care and I am in agreement with the above plan of treatment.

_____ _____
Physician Signature Date

_____ _____
Service Provider Signature/Title Date

Appendix 8-G Progress Summary 2

Name_____ Teacher:_____

Diagnosis:_____

Precautions / Contraindications:_____

Physician:_____ Current orders:_____

Concerns list / need areas:_____

Long term goals:_____

Objectives:_____

Progress toward objectives since last report:_____

Methods to achieve objectives:_____

Requested changes in physician order:_____

_____ / _____ _____ / _____

Physician Signature Date Service Provider Date

Appendix 8-H Progress Summary 3

Name_____ Period of Coverage:_____

Precautions / Contraindications:_____

Diagnosis:_____

Physician:_____ Teacher:_____

Current orders:_____

_____

Long term goals:_____

_____

Comments:_____

_____

_____

_____

Need	Objective	Progress			Method/Plan

Progress Codes:

0 - No change
1 -
2 -
3 -
4 -
5 - Attained Goal

Requested changes in Physician's order:

Physician_____date_____ Service Provider_____date_____

_____date_____ _____date_____

_____date_____ _____date_____

Appendix 8-I **Progress Summary 4**

SERVICE PROVIDER'S REQUEST FOR PHYSICIAN'S ORDERS
INITIAL: ___ CONTINUE: ___ CONTINUE WITH MODIFICATION: __

STUDENT NAME:

SERVICE PROVIDER NAME: ID NUMBER: ☐☐☐☐☐☐☐☐☐

DIAGNOSIS: (ICD 9 CODE) ☐☐☐☐☐☐ DESCRIPTION:

TREATMENT PLAN

PERIOD OF SERVICE AND FREQUENCY

FROM: _____ (DAY MO YEAR) TO: _____ (DAY MO YEAR) FREQUENCY: _____ (X'S PER)

CURRENT LEVEL OF FUNCTIONING: _____

IDENTIFIED NEEDS AREAS: FROM IEP DATED:

LONG TERM GOALS: _____

SHORT TERM OBJECTIVES: _____

PROGRESS SUMMARY

STUDENT PROGRESS TOWARD GOALS SINCE LAST REPORT:

_____ _____
SERVICE PROVIDER SIGNATURE/TITLE DATE

MEDICAL ORDERS: _____

PRECAUTIONS/CONTRAINDICATIONS: _____

I have reviewed the IEP and agree to the plan of treatment as outlined in the goals and objectives.

_____
PHYSICIANS SIGNATURE EFFECTIVE DATE

PT ☐ OT ☐
SLP ☐ AUD ☐
Psyc ☐ Other ☐

Progress Summary 5

Student Name_____ Diagnosis & ICD-9_____
School_____ Frequency of Service_____
Period of Coverage From:_____ To:_____ Precautions/Contraindications_____
Long Term Goals_____

Summary of Progress	Objectives	Treatment Plan Methods / Approaches

Physician Comments:_____

_____ Service Provider / Title _____ Date

_____ Physician Signature _____ Date

Physician signature certifies review of progress and renews treatment orders.

Appendix 8-K

Consultation Report

Name:_____ DOB:_____

Treatment diagnosis:_____

Physician_____ Teacher_____

Reason for Consultation:

Results:

Recommendations:

_____/_____ _____/_____

Physician Signature Date Service Provider Date

Appendix 8-L

Discharge Summary 1

STUDENT INFORMATION

STUDENT NAME:_____ BIRTH DATE:_____

STUDENT ID#:_____

PRIMARY DIAGNOSIS_____

_____ ICD9 CODE:_____

REFERRING PHYSICIAN_____

I. Date treatment initiated: _____Date treatment discontinued:_____

II. Long term goal

III. Summary of course of treatment:

IV. Recommendations / Follow-up:

V. Home Programs / Referrals

_____ _____

PHYSICIAN SIGNATURE DATE

Appendix 8-M

Discharge Summary 2

Name:_____ DOB:_____

Treatment diagnosis:_____

Physician_____ Teacher_____

Date treatment initiated:_____ Date treatment discontinued:_____

Comments:_____

Long term goal:_____

_____ Achieved? ☐ Yes ☐ No

Summary of course of treatment:

Recommendations / Follow-up:

Home Programs / Referrals:

_____ / _____ _____ / _____

Physician Signature Date Service Provider Date

Appendix 8-N

Sample

Letter to Parents

Dear Parents:

We are pleased to provide special education services to your handicapped child. In an effort to maintain the highest possible quality of special education services for all handicapped students in the School District of_____, we are seeking all possible sources of funding available to the district. As the amount of public funds expected in the future is always uncertain, the School District of _____ is leaving no stone unturned in its efforts to find alternative or supplemental sources of revenue to meet the special eduction needs of our students. The federal government and the United States Congress have encouraged school districts to make use of any and all sources of funding available, including benefits payable through insurance companies, and Medical Assistance.

We have found that many services provided by our ancillary professional staff (physical therapists, occupational therapists, speech language pathologists and psychologists) to children and youth with handicapping conditions may be covered by their parents' group health insurance or Medical Assistance.

The School District of _____ would like your permission to submit these claims to your insurance company and will use any reimbursement received to help cover the costs of special education. **This will only be done with your approval and there will be no cost to you.** Even if your insurance carrier does not make any payment for these services, **they will still be provided free of charge to your child.**

In order to submit a claim to your insurance company, the School District of _____ _____ needs your **voluntary** approval. Assuming you do approve, please sign the attached Parental Consent Form.

If you have any questions, please feel free to contact me.

Sincerely,

*(*Adapted from form used by Independence Public Schools, 1231 South Windsor, Independence, MO 64055)*

Appendix 8-O

Parental Request for Forms Completion and Submission of TPR Claims

Date

Dear (*parent's name*)

Re: (*student's name*)

In an effort to maintain the highest possible quality of special education services for all students with handicaps, (*name of school district*) is seeking all possible funding sources to pay for services. The federal government and the U.S. Congress have encouraged school districts to use any and all sources of funding, including Medicaid and insurance benefits, to finance special education and related services.

We know that many related services provided by our professional staff as part of your child's Individual Education Plan may be covered by Medicaid and insurance carriers. Related services include physical and occupational therapy, speech-language pathology, audiology, and psychological services.

(*Name of school district*) is requesting your voluntary permission to submit claims to your carrier and/or Medicaid. Our district will use the reimbursement to cover the cost of services provided. Insurance/Medicaid benefits can only be accessed with your permission. All services outlined on your child's IEP will be provided free, regardless of third party insurance or Medicaid funding.

Please complete and sign the (*list names of forms included for completion, i.e., Insurance Identification/Information forms and Release of Information forms*) enclosed and return as soon as possible. Retain the yellow copy for your records.

If you have questions and/or concerns regarding the access or use of your insurance and/or Medicaid funds for special education and related services, please call (*name of contact*) at (*telephone number*). Your cooperation and help with this process will allow us to continue to provide the highest quality of special education and related services to our students.

Sincerely,

Director of Special Education

Appendix 8-P

School District of _____

Parent Consent Form

Name of Child:_____Student Number_____

Parent(s) Name:_____

I. Supplementary Information to Insurance Carrier

Specific services have been provided by the School District of _____ to my handicapped child in fulfillment of the School District's obligation to provide all handicapped children a free appropriate public education, as required by federal and state statutes. See 20 U.S.C. 1412 (1976). The services are provided "without charge." See 34 C.F.R. 300.4(b) (1982).

The School District of _____ has designated _____ as the billing agent to submit insurance and Medical Assistance claims to third party payors under a Billing Agent Agreement.

The obligation of the School District of _____ to provide a free appropriate public education does not relieve an insurer from an otherwise valid obligation to pay for the services provided to a handicapped child [34 CFR 300.301(b)(1982)]. The United States Senate Committee of Labor and Public Welfare reported favorably on the Education for All Handicapped Children Act (P.L. 94-142) with the comment that the state's obligation to provide special education and related services at no cost to the parents of a handicapped child "is not to be construed to prohibit charges by the educational agency to insurers, public programs, and others for hospital care, health services, rehabilitation, and other noneducational services. States are encouraged to utilize all sources of support for comprehensive services for handicapped" [S. Rep. No. 94-168, 94th Cong., 1st Sess.32 (1975)].

II. Authorization of Services

I, the parent (guardian) of _____ authorize the School District of _____ having jurisdiction over my child to provide to my child necessary and appropriate services by the licensed providers employed or retained by the School District of _____.

I understand that the services will be provided to my child even if I do not consent to allow the School District of _____ to submit a claim under my insurance policy.

_____ _____

Parent Signature Parent Name *(Please Print)*

_____

Date

Appendix 8-P continued

Parent Consent Form (continued)

III. Authorization of Insurance Claim

I voluntarily consent to submission of a claim(s) to my insurance carrier for payment under my insurance policy of the fees for the services provided to my handicapped child. I authorize the School District of _____ to submit such a claim through _____. I understand that the School District of _____ will absorb all deductible and coinsurance charges under my policy with respect to the claim.

I request and authorize my insurance carrier to communicate directly with _____ as billing agent for the School District of _____ under my policy. I request and authorize the payment of insurance proceeds to _____ as the billing agent for School District of _____.

If I am eligible for Medical Assistance benefits, I request and authorize payment of Medical Assistance benefits to _____, the billing agent for the School District of _____.

_____ Parent Signature

_____ Parent Name (Please Print)

_____ Date

IV. Authorization of Release of Information

I authorize the release of any medical information (1) by the School District of _____ and the provider of the service to the billing agent for the School District of _____, and (2) by the billing agent for the School District of _____ to my insurance carrier as necessary to process the claim to be filed or to request payment of Medical Assistance benefits.

_____ Parent Signature

_____ Parent Name (Please Print)

_____ Date

V. Depletion of Policy Benefits

If you must make a claim on your insurance during a policy year and in the unlikely event the benefits of your policy are exhausted due to claims made by the School District of _____, the School District of _____ will reimburse you for covered costs to a level that does not exceed the amount of money received by the School District of _____ from the insurance carrier.

*(*Adapted from a form used by Independence Public Schools, 1231 South Windsor, Independence, MO 64055)*

Appendix 8-Q

STUDENT IDENTIFICATION INFORMATION

SCHOOL NO. _____ SCHOOL NAME _____ DATE: _____
DISCIPLINE (Therapy Type) _____
STUDENT'S LAST NAME _____ FIRST NAME _____ INITIAL _____
STREET _____
CITY _____ STATE _____ ZIP _____
CLIENT'S DATE OF BIRTH _____ MALE _____ FEMALE _____
REFERRING PHYSICIAN (First & Last Name) _____
PHYSICIAN ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHYSICIAN'S PROVIDER # _____

ICD 9 CODE/DIAGNOSIS 1. _____
2. _____
3. _____
4. _____

M.A. #: ☐☐-☐-☐☐☐-☐☐☐-☐☐☐☐-☐☐☐

INSURANCE INFORMATION

CARRIER NAME: _____
STREET: _____
CITY _____ STATE _____ ZIP _____
GROUP # _____ POLICY # _____
AUTHORIZATION # (IF APPLICABLE) _____
EMPLOYER NAME: _____
POLICY HOLDER/SUBSCRIBER/INSURED NAME: _____

SUBSCRIBER / INSURED HOME ADDRESS:

STREET _____
CITY _____ STATE _____ ZIP _____
PHONE # _____
RELATIONSHIP TO CLIENT _____

FORM COMPLETED BY _____

Appendix 8-R

Insurance Information and Authorization Form

STUDENT INFORMATION

STUDENT NAME:_____ BIRTH DATE:_____
PARENTS NAME:_____
ADDRESS:_____
CITY, STATE, ZIP:_____

PHYSICIAN NAME:_____
ADDRESS:_____
CITY, STATE, ZIP:_____
TELEPHONE:_____

INSURANCE INFORMATION

FATHER
NAME:_____ WORK PHONE:_____
PLACE OF EMPLOYMENT_____
SOCIAL SECURITY NUMBER:_____
INSURANCE COMPANY NAME:_____
ADDRESS:_____
CITY, STATE, ZIP:_____
GROUP NUMBER:_____ POLICY NUMBER:_____

MOTHER
NAME:_____ WORK PHONE:_____
PLACE OF EMPLOYMENT_____
SOCIAL SECURITY NUMBER:_____
INSURANCE COMPANY NAME:_____
ADDRESS:_____
CITY, STATE, ZIP:_____
GROUP NUMBER:_____ POLICY NUMBER:_____

STUDENT'S MEDICAL ASSISTANCE NUMBER:_____

AUTHORIZATION FOR INSURANCE CLAIM

I CONSENT TO SUBMISSION OF CLAIMS TO MY INSURANCE CARRIER FOR PAYMENT UNDER MY INSURANCE POLICY OF THE FEES FOR HEALTH RELATED SERVICES TO MY CHILD BY _____. I UNDERSTAND THAT THE SCHOOL DISTRICT WILL ABSORB ALL DEDUCTIBLE AND COINSURANCE COSTS ASSOCIATED WITH MY POLICY WITH RESPECT TO THIS CLAIM.

I AUTHORIZE MY INSURANCE CARRIER TO MAKE THESE PAYMENTS DIRECTLY TO _____.

_____ _____ _____
FATHER'S SIGNATURE MOTHER'S SIGNATURE DATE

AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION, BY_____, TO MY INSURANCE CARRIER AS NECESSARY TO PROCESS THE CLAIM.

_____ _____
PARENT'S SIGNATURE DATE

Sample Billing Log

Student Name _____ Student ID No. _____

School _____ Month _____ 19____

Service Provider _____ Discipline Type _____

Authorization/Reauthorization Number _____

Period of Coverage _____

MONTHLY CALENDAR

Service	Procedure Code	Total Units	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

SPECIAL NOTES

☐ PT ☐ OT ☐ SLP ☐ PSY ☐ AUD ☐ MED

_____

Signature of Service Provider

Appendix 8-S(a)

Supplemental Progress Note Form to Billing Log

Date	Goal	Goal	Goal	Goal	Progress Notes

Time Sheet or Billing Log

SCHOOL _____
SERVICE PROVIDER _____
DATE: _____

WEEK ENDING _____

STUDENT NAME ID #	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	TOTAL UNITS	TOTAL CODE
TOTAL DIRECT TIME							

Appendix 8-U

Billing Log

School_____ Month_____ 19____

Provider Name_____ Provider #_____ Service Type_____

Student Name & #	ICD-9#	Procedure Code	units of service per day 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	SUB T	units of service per day 16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	MONTH TOTAL
Student Name & #																																		
Student Name & #																																		
Student Name & #																																		

Appendix 8-V

Physician Telephone Order

PHYSICIAN'S TELEPHONE ORDERS

Last Name	First Name	Attending Physician	Room No.	Admission No.

Date Ordered	ORDERS

Signature of Nurse Receiving Order	Time	Signature of Physician	Date

Physician Please Sign and Return Within 48 Hrs.

Appendix 8-W

Physician Introduction Letter

Date

Dear Dr.

Re: Student's Name

The parents of the above named student have identified you as their child's physician. The student is currently receiving educational and "related" services at (*name of school*). Related services are defined as physical and occupational therapy, speech-language pathology and audiology, nursing and psychological services.

P.L. 94-142 and P.L. 100-360 have clearly indicated that all sources of funding should be utilized to pay for special education and related services. The school district is mandated to provide the services regardless of funding availability.

The concept of accessing Medicaid and other third party payors has been foreign to most school districts until recently. However, schools are now facing a serious financial crisis and are seeking to support special education and related services through alternative sources. In order to utilize third party reimbursement, authorization from the student's physician is required.

We are seeking your initial and continued authorization for services. Please review the attached request, sign and return the form in the enclosed self-addressed envelope. Please retain a copy for your records. You will continue to receive a current summary outlining goals, objectives and progress on a regular basis.

Thank you for your consideration and help in this matter. Please call (*name of contact person*) at (*telephone number*) if you have any questions or require additional information.

Sincerely,

Director of Special Education

Appendix 8-X

Physician Permission to Assess

STUDENT NAME: DOB:

PARENT NAME:

ADDRESS:

CITY, STATE, ZIP:

PHONE:

REFERRING PHYSICIAN:

PHYSICIAN PLEASE PROVIDE THE FOLLOWING INFORMATION:

PRIMARY DIAGNOSIS:

ICD9 CODE

ASSESSMENTS REQUESTED

- ☐ OCCUPATIONAL THERAPY
- ☐ PHYSICAL THERAPY
- ☐ SPEECH-LANGUAGE PATHOLOGY
- ☐ AUDIOLOGY
- ☐ PSYCHOLOGY

SIGNATURE OF PHYSICIAN DATE

RETURN TO:

Appendix 8-Y

Progress Summary Chart

Student Name	JAN		FEB		MAR		APR		MAY		JUNE		JULY		AUG		SEPT		OCT		NOV		DEC	
	Date Sent	Date Rec'd	Date Sent	Date Rec'd	Date Sent	Date Rec'd	Date Sent	Date Rec'd	Date Sent	Date Rec'd	Date Sent	Date Rec'd	Date Sent	Date Rec'd	Date Sent	Date Rec'd	Date Sent	Date Rec'd	Date Sent	Date Rec'd	Date Sent	Date Rec'd	Date Sent	Date Rec'd

Appendix 8-Z

Tracking Log — TPR

STUDENT:

ID SENT	INFO/AUTH. REC'D	INITIAL PHYSICIAN SENT	AUTH. REC'D	OT S	EVAL R	SLP S	EVAL R	PT S	EVAL R	PSY S	EVAL R

Service Area	Dr. Initial Orders		Dr. Con't Orders		Progress Notes		
	Sent	Rec'd	Sent	Rec'd	Month	Rec'd	Billed

Appendix 8-AA

School:

	STUDENT	SERVICES	PHYSICIAN AUTH. SENT	PHYSICIAN AUTH. RETURNED	INS. OR HMO AUTH.	1ST PROG. SUMMARY SENT
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
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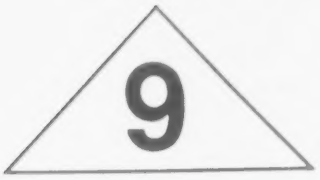


Implementation

Implementation of a third party reimbursement system will not be an easy task for any school district, regardless of its size. This book provides districts with the parameters necessary to ensure that the decision to implement a system is based on sound information and data. The formats and process tools provided herein can enable districts to establish a successful third party reimbursement system.

Developing this new entity within the established special education process will first require school districts and their administrations to address the issues outlined in chapter 2 as they relate to their individual state and community. All of the issues may not need to be addressed by each district, but it is crucial to the success of any third party reimbursement system that the issues that pertain to the individual district be addressed. The philosophies and objectives for any third party reimbursement system must be developed in relation to the issues that affect individual districts.

The philosophies and objectives developed by the district also need to be disseminated by the district's administration to families, insurers, special education related staff, state and regular education personnel, community providers and legislators. Implementing a third party reimbursement system will require a significant amount of positive leadership when disseminating information, providing the necessary staff with training and completing strategic review of the success of the system. Positive attitudes, combined with accurate data, sound philosophies and concrete objectives, will assure smooth implementation of the third party reimbursement system.

Once districts resolve to move beyond the issues by developing concrete objectives for implementation, they will need to review the data regarding their current special education system and the reimbursement options within their state and geographic area. Chapter 3 provides suggestions regarding resources that districts may want to review when gathering data prior to implementation. The data parameters include review of the district's special education process and the number of students eligible for related services, the credentials of currently employed related services personnel, community resources and system options. Chapter 5 provides data regarding the range of procedure and diagnostic codes and the tools

districts will need to use to establish fees for related services. Chapter 7 provides resources for data gathering in regard to the types of third party coverage available. When attempting to estimate potential reimbursement, districts may be able to review already available data regarding the types of health carrier sources within their community, but these data may be difficult to acquire in urban areas.

Once data are collected and analyzed, district administrators will need to outline advantages and disadvantages as they relate to the objectives and philosophies they have developed. As implementation of the third party reimbursement system proceeds, it is crucial to the system's success to disseminate information in a positive manner and to indicate to all sources that all issues cannot be addressed during the implementation process. Some issues in fact cannot be resolved by individual districts through data gathering, but only by moving forward with implementation. Only then will the district be able to judge whether or not access of third party reimbursement meets the objectives developed.

As the evaluation of data concludes and districts determine what populations to target with implementation, the type of billing system must be selected. The scope of the target population will influence the district's choice of a billing system. If a district targets a small population for only a pilot project as opposed to all special education related services, contracting for billing services rather than developing its own computerized billing system may be appropriate. Chapter 4 provides a discussion of the system options available.

Once the target population and the system option are identified, districts will need to outline the procedures needed to implement the system and develop the necessary documentation forms. Implementation procedures include establishing an internal system for disseminating carrier information and documentation. The district will need to establish procedures for obtaining physician authorization, student identification and carrier information, and parental consent. Districts must establish administrative procedures and must allocate personnel for obtaining the documentation necessary to initiate billing and to retain clinical records. Establishing a centralized procedure is optimal.

Districts will need to define technical assistance requirements once the target population and procedures are defined. The Departments of Health, Human Services and Education, as well as independent consultants, billing agents, local community providers, insurance companies and professional associations, can provide technical assistance. Districts are encouraged to seek resources outside the realm of education to assist in implementation of a third party reimbursement system. The parameters necessary to implement a third party reimbursement system within education are similar to those of community health care providers. They are broad in scope.

It is cumbersome and confusing to require individual service providers to maintain all the documentation necessary to a third party reimbursement system. Thus, districts need to establish a central location and employ trained personnel to assist with all the documentation outlined in chapter 8. The district should maintain control with regard to system documentation and information collection to ensure that good relationships are maintained with all sources involved. The school district is accountable for all documentation parameters, including physician authorization, parental consent and service provider documentation.

Once the district has established an organized procedure for assisting with the dissemination and control of all documentation forms, the forms must be developed and printed. Districts may choose to involve direct service staff in the development of the necessary forms, as outlined in chapter 8, because staff who participate in the development and implementation processes will retain ownership in the system and foster its success. It is important for the district to develop their standardized procedures for documentation prior to the introduction of printed forms to related staff. Service providers will be more accepting of the system if the procedures are outlined in a positive manner.

In-service education and information sessions will need to be completed with district staff, parents, families and community providers following the development of standardized procedures for the system implementation and printing of documentation forms. Training of related service providers is a critical component for successful implementation of any third party reimbursement system. Districts must provide staff with the full scope of information, including the issues, the established philosophies and objectives, training and follow-up support. Parents and families will be more willing to consent to access of their health insurance coverage when they understand the district objectives and the benefits to special education services for their child.

Evaluation regarding the successful implementation of the third party reimbursement system can only be determined once the procedures and billing formats are established, staff and student families are informed, the cooperation of community providers has been obtained, services are provided, documentation is completed and a claim form has been submitted. It will be at least 18 to 24 months before evaluation of the system's implementation can be assessed.

States that have implemented third party reimbursement systems have indicated that initial reimbursement for claims filed is slow and that the learning process that districts must endure influences collections. Districts should not view third party reimbursement as a "pot of gold." However, there are additional funds that can be used to support special education available through third party reimbursement.

Districts will need to consider the following variables when evaluating their system's success: degree of parental cooperation; positive and/or negative changes in the quality of services; models of intervention; additional staff time necessary for documentation; billing system costs; net revenue; coordination of services; legal implications; and state legislative implications. Districts should include methods for evaluation when developing strategic plans for implementation of a third party reimbursement system.

The following outline provides a checklist for districts as they implement their third party reimbursement system.

_____ Identify issues

_____ Develop and disseminate philosophies and objectives for implementation of a third party reimbursement system

_____ Gather data necessary to make an educated and informed decision regarding scope of system implementation

_____ Outline advantages and disadvantages relative to objectives

_____ Define target population and develop strategic plan for implementation and system evaluation

_____ Project positive attitude regarding implementation and benefits

_____ Establish billing system

_____ Define procedures

_____ Develop documentation forms

_____ Educate personnel, parents and community providers

_____ Gather student information, financial reimbursement information, parental consent and authorization forms

_____ Provide related services as outlined on IEP

_____ Document services by third party payor standards

_____ Input student and billing data for completion of claim form

_____ Produce a claim form

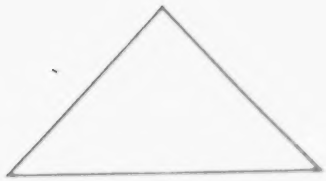
_____ Submit claims to appropriate payor source

_____ Post payments

_____ Establish system to track claim denials for resubmission

_____ Evaluate and analyze system success

This text has provided school districts with the law, the issues, the parameters and the tools needed to implement a third party reimbursement system. The task will not be easy. However, the increased funding may provide lower caseloads, more appropriate services, and fewer unserved or underserved special education students. So the effort will be "worth it." Only through implementation of a third party reimbursement system combined with strategic evaluation will school districts be able to determine the system's success.



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